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Between Ourselves

One hundred months is a long time—eight and one-third years. Looking ahead it seems an endless period. As this month's issue, ***our one-hundredth,*** goes to press the time seems very short since the morning in 1944 when, full of misgivings, we launched Vol. 40, No. 7. The lapsed time seems unbelievably short. Now, as then, our goal is to provide the best material that we can procure. With the active cooperation of nurses in every part of Canada, as well as doctors and other specialists, we look forward happily to the next hundred issues.

* * *

Reference has already been made to the interest that **Abbé Arthur Maheux** aroused when he delivered the ***Mary Agnes Snively Memorial oration*** during the C.N.A. convention. It is available in this issue for subscribers in both languages.

It was noted in the August issue that reprints would be prepared following publication of this address. Due to the fact that the demand for reprints of previous orations was so small, the C.N.A. has decided to dispense with them this year. While the supply lasts, extra copies of this issue may be secured from the *Journal* office for 35 cents each.

* * *

The oncoming winter season is marked by an increased incidence of ***pleurisy.*** Here to describe this complication of many diseases, and the essentials of nursing care, are **Dr. S. Marcus** and **Martha Aldrich,** both of Sherbrooke, Que.

Most commonly pleurisy occurs as an extension of a disease process in the lung—pneumonia, tuberculosis or a pulmonary infarct. Inflammation may spread out from an abscess in the surrounding chest wall or the pericardium to the pleura. Occasionally, pleurisy may be a symptom during a systemic disease such as acute rheumatic fever or leukemia. Usually, the first intimation of the condition is a sudden "stitch" in the side.

* * *

There is a common saying that a nurse is more considerate of and more understanding about her patients' demands upon her after she has had the experience of being confined to a hospital bed herself. Since we are not wishing for any of our readers the discomforts of an operation we are giving you an opportunity to look behind the scenes, so to speak, at what a ***patient's normal reactions*** are likely to be. **Patricia Jones** is the nom de plume of a well known professional woman who was forced to undergo eye surgery. Her reactions were typical of those of hundreds of patients.

* * *

Directors of schools of nursing who are responsible for the selection of candidates, and educational directors who are charged with the training of the students once they have entered the school, will be interested in **Marjorie Fahrig's** study and findings relative to ***the use of an aptitude test for nurses.***

Prior to undertaking study in psychology, Miss Fahrig was trained and worked as a medical laboratory technician for seven years. During this time she lectured to probationary students and became interested in nurse selection procedures. This piece of research was the result of this interest.

* * *

The course in nursing offered at the Toronto Western Hospital continues to attract interest and speculation as observations are made on how this two-year basic course plus one year of salaried interneship operates. **Margaret Mackenzie,** as health instructor, is in complete charge of the ***health education program*** provided for the students. Her detailed explanation of how the program functions and what is included in it may well serve as a guide to other schools of nursing in the expansion of their programs. The position of this article on the Public Health Nursing Page is evidence of the varied values this article possesses.

* * *

That very busy person whose ***informal, information-packed letters*** have been enjoyed by *Journal* readers for the past two years, **Lyle Creelman,** has recently returned to Canada for a period of study. The current letter is almost the last we shall have for several months. We shall watch for their return.

God will not look you over for medals, degrees and diplomas but for scars.—FRA ELBERTUS.

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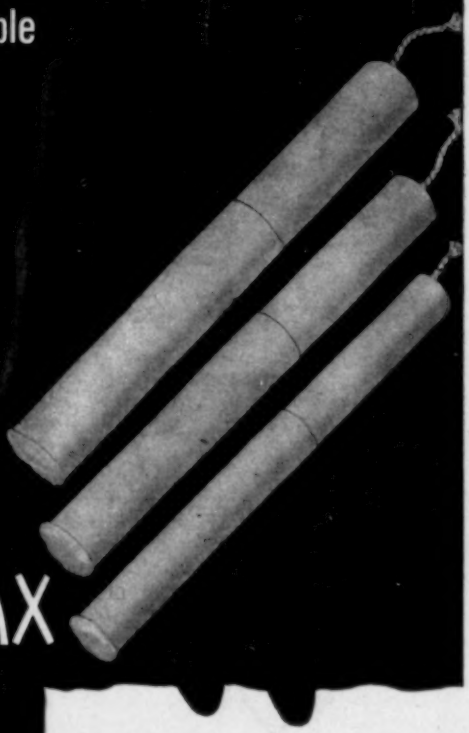

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Administration — Usual dosage in mental and emotional disturbances is 1 tablet 2 or 3 times daily; in obesity, 1 to 2 tablets 30 to 60 minutes before each meal.

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Achieving Understanding

ABBÉ ARTHUR MAHEUX

The problem of national unity may be considered in many different ways. I have endeavored for many years to explain that problem throughout Canada—by lectures, booklets, contributions to various periodicals, and especially by books. I do not pretend to have solved all the difficulties. My weekly articles in the *Montreal Star,* 360 in seven years, have offered a great variety of details on the same subject. The best way, of course, is to go directly to the roots. There is no doubt that the roots of our national problems are our prejudices.

Let us approach the topic from another angle and consider the relationship between national unity and Laval University. It has often been said that the French Canadians have been very late in establishing a university; that, for lack of such an institution, they have been relatively ignorant, consequently despicable. Is that true?

Your convention is being held at Quebec at the time of the centenary of Laval University—the centenary of the granting of a Royal Charter in 1852 to the Quebec Seminary. It is not, however, the centenary of teaching at university level in New France or among the French Canadians.

To find the origin of such teaching we must go back as far as 1635. In that year, a few months before Samuel de Champlain died, the Jesuits opened a college on the heights of Cape Diamond, not far from the residence of the Governor, in front of the present-day Basilica. It was a "classical college"—that is, a combination of high school, for the first four years, and of a college of Arts and Sciences, for the last four years. Preceding these eight years, there were elementary classes for those who were not sufficiently prepared to study latin. After these eight years there was higher teaching in practical sciences, such as navigation, surveying, mathematics.

The Jesuits' College was organized along the very same lines as their colleges in France and other parts of Europe. These colleges were already famous in Europe for the excellence of their teaching. It certainly was a daring feat to open such an institution in Quebec, when the total population of that village and the surrounding farms amounted to not more than 300 persons, leaving very few chil-

dren to attend the classes. Yet the Jesuits were spurred to that audacity by what had happened in Spanish America, where colleges had to be opened very early after the settlement of white people The ambition was the same for France as for Spain —to train and educate the Indians as well as the white people. The Indians did not do well and had to be finally excluded but the institution stood and was operated for the white colonists.

The Jesuits were alone till the arrival of the first bishop—Monseigneur François de Montmorency Laval in 1659. His first care was to organize a seminary for the training of young men to priesthood. That was done by a Royal Charter *(lettres patentes)* obtained from the King of France in 1663. Hence the teaching of theological sciences began early and at the same level as most of the European theological colleges. Right then New France had the equivalent of two faculties—arts at the Jesuits' College and divinity at the Seminary.

Bishop de Laval was not satisfied with the accomplishment. In 1668 he decided to have his own Petit Séminaire that would also be a classical college. However, since the population was not numerous enough for two colleges, especially in the same locality, he made an arrangement with the Jesuits. He would send to their college his seminary students for the classics and he would give the rest of the training in his own institution. That combined system operated for the duration of the French Régime, till the Seven Years War forced both institutions to close their doors under the bombardment made by Wolfe from the heights of Lévis. Consequently we can say that teaching at university level has been a permanent institution in New France since 1635 for Arts and since 1663 for theology. The third centenary of the Jesuits' College was celebrated in 1935. The third centenary of the Quebec Seminary will be celebrated in 1963.

But, you may ask, what was done for law and medicine. Very little, indeed, is my answer. Lawyers were not well considered in New France. Justice was administered by the seigneurs, each seigniory having its own courts, and by the Conseil Souverain in which sat the governor, the intendant, the bishop, and a few others. A certain Mr. Verrier gave some public lessons in law. For medicine there was only apprenticeship with a surgeon or physician. Of course, it would have been easy to organize courses in law and medicine. Even in France such faculties were operated with very few professors and very few students. But the government at Paris was not very generous towards the colony in such matters. Small grants in money would have been very useful for higher teaching in New France but we had to wait, as we did for printing, which was not allowed here during the French Rule, while it began in the English colonies as early as 1639.

The Jesuits' College and the Quebec Seminary operated without the power of granting diplomas. This did not impair the value of the teaching. It was really at university level and was not inferior to the teaching given in France and in other European countries, including England. It was as good as the teaching given in the English colonies. Harvard began in 1636 as a classical college which later developed into a full fledged university, just as the two Quebec institutions were to merge later and finally become a complete university.

When did that combination come? It was a result of the Seven Years War and of the Treaty of Paris (1763) and of the new policy of Great Britain toward the French Canadians. The new English power was Protestant and would normally act as Protestant. One of the first decisions was against the Religious Orders, namely the Jesuits and the Recollets. They were not killed nor exiled but they were not allowed to take new novices nor to continue their teaching. The members would die one after one and finally the Order would become extinct and their properties would return to the state or government.

Such a decision meant a very great change for the French Canadians and some new arrangement was essential. James Murray understood well the situation. He saw clearly that a clergy was necessary for the French Canadians and, consequently, a bishop and a seminary. He

favored the appointment of Olivier Briand, as Bishop of Quebec, and he gave permission to the Quebec Seminary to continue as a teaching institution. The teaching of theology, partly interrupted by the war, was resumed and completed. As for the classics, the Seminary succeeded the Jesuits, adopting their books, programs, methods, etc. The priests composing the faculty of the Quebec Seminary had been students of the Jesuits, either in Europe or at Quebec. So, in 1765, after the buildings ruined by bombs had been restored, the classical course was re-established at the Seminary. From then on the Seminary took as students not only those who wanted to become priests but all young men who would like to study. It became a college instead of just a seminary. It certainly was an arduous task for the priests of that institution but they managed very well. They wanted a very strong course of studies and they reached that level. The final examinations, in the higher classes, were held in public. Theses were prepared, read, and defended in public. There was no diploma but there was a public recognition of talent and success. The young man, after eight years of training in classical languages and literatures, in history and geography, in philosophy and sciences, could enter administration, theology, politics, commerce, the Bar, medicine and surgery, with additional years of study or service with a lawyer or a doctor.

However, the idea of a full university was not dead. It remained alive among both the French and the English-speaking Canadians. The French were really favored, having a classical and theological college, and even more when new similar colleges were opened in other localities. The English Canadians had only private institutions—one-man grammar schools. They did not want to send their sons or daughters to American schools. For a long time they preferred registering them in the French-Canadian colleges, particularly at the Seminary at Quebec.

I feel pretty sure that it would have been easy for the French Canadians to obtain a university charter in 1774, when they had the Quebec Act. At that time they obtained confirmation of their right to remain Catholic, to maintain the seignioral system, the tithes, and more, the dispensation from the oath of Test. All these concessions from Great Britain were hard sacrifices coming from a decidedly Protestant government. They were obtained with the help of Governor Carleton. Consequently if the French Canadians had asked for a complete university they certainly would have obtained it; but they did not ask for it.

Later, the English wanted a university. They foresaw a sort of state university that would be neutral in religion. All the students would have followed the same courses, except theology, where two separate colleges, one Protestant and one Catholic, would have been necessary. The Catholics did not like the idea of neutrality and the Dissenters hated the idea of a theological college which would have been Anglican. Eventually the project, legally named the Royal Institution for the Advancement of Letters, Arts and Sciences, became McGill College, through a legacy made by James McGill at Montreal. McGill began just as a college of arts, a position similar to that of the Jesuits' College and the Quebec Seminary. The same must be said of King's College which became the University of Toronto and other now existing Canadian universities.

The need of a university became more and more felt, especially when the Bar was established, when the medical men had a Bureau of Examiners, when lawyers and physicians migrated to Canada from the British Isles, when various medical institutes sprang from the new American soil, when McGill pushed forward with the power of granting degrees. These are reasons to be kept in mind.

Other reasons, however, urged upon the the French Canadians the idea of a university. The main one is to be found in the Durham Report. Like most Canadians you may not have read that Report, which so deeply influenced the development of Canada. I believe that all Canadians, at least educated Canadians, should read it. Durham was sent here in 1838 by the British Government, in order to calm the rebellion which raged both in Upper and in Lower Canada. He made an intensive inquiry into the situation, either personally or by his agents. His report was presented to the House of Commons in London in January, 1839. It must have

been a sort of scandal for the British Government, for Durham had only blame for that government. He had mostly blame for the English Canadians. As for the French Canadians he rather praised them in the first part and he scorched them in the last part.

One paragraph has been retained—the one in which he said that the French Canadians were a people of no history, no literature, no drama, no fine arts. Of course, he meant that actually they had not written a history, or literary works, or plays, and had not produced works of art. In that last case he was wrong, a fact that has been abundantly proven by various books of historical research and which is presently proven by the Exhibition of old French Canadian Art at the Provincial Museum. He was right for the rest. Garneau's "Histoire du Canada" had not yet been printed. Our first literary movement dates only of 1860. As for drama there was nothing of the sort, since the church prohibited the people from going to theatre. Durham never meant that matter was lacking for writing historical, literary, and dramatic works. Yet that was understood by a good many French Canadians.

Durham's Report was considered as a final condemnation of the French Canadians as lacking culture. The recommendations of the Report were implemented in the Union Act of 1840, and then began a supreme assault against the French-speaking group. The official use of the French language was abandoned, at least for a few years. The Catholic religion was attacked, especially by the French-Canadian Missionary Society. Politically the French Canadians were merged into the English-speaking community, so as to counterbalance their numerical influence.

These were really hard times for Jean-Baptiste but his spirit of resistance had been underrated. Only four years after the Durham Report, the French came to the fore with a plan for a university, thinking that only such an institution could save them. That plan was based on the use of the Jesuits' Estates. It was under consideration for four years and then abandoned because it was felt that the British Government would not give away those Estates. That failure made the French Canadians only more desirous of having the university. They turned their eyes on that old institution, the Quebec Seminary, which had seigniories, farms, houses for rent and, above all, the respect and esteem of all the people for its academic accomplishments. The Seminary yielded to the pressure and, with the help of the Governor General, it obtained a Charter for a university from Queen Victoria in 1852. You may see now, what importance the French Canadians give to the centenary of our Charter.

There is presently full evidence that their ancestors were right in thinking that salvation resided in the organization of a full university. How much cultural work has been done during 100 years is easy to see in this year 1952. Literature, history, philosophy, and sciences all have well organized courses. Thousands of young men and young women are prepared every year for more than 50 different careers and they are in great demand everywhere.

One of these careers is nursing. It is relatively new in Laval University, since the first school of nursing was affiliated in 1923. The first courses for the degree of Bachelor in Nursing date only from 1933. Yet, even there, one must look at the historical data. Nursing in New France is as old as the colony itself. Officially New France began with the foundation of Quebec in 1608; but it remained in a very precarious condition until 1633 when, after the Treaty of St. Germain-en-Laye (1632), a new beginning came for the colony. Six years later (1639) the first nurses came from France to open the first hospital in Quebec—l'Hôtel-Dieu—still existing today. This was a bold move, since the population was still very scarce. Let us consider that these nuns had no other purpose than nursing, for the teaching was given at the Ursulines. Of course they had no university diploma, no other diploma than their good will and a general education. As for the technical part of their work, they depended upon the physicians, surgeons, and druggists of the time. One of these men was the main doctor of the hospital but all were admitted to treat the patients. The registers show that even the surgeons of

the incoming ships were accepted at the Hôtel-Dieu. With the hard climate, with the frequent epidemics, with the seamen from various parts of the world, there was a sufficient variety of cases. These conditions made for a better practice on the part of physicians and for a better apprenticeship on the part of future physicians. Later the Hôpital Général was established. Under the English rule the Hôpital de la Marine was open and the asylum for mental diseases.

The nuns of the Hôtel-Dieu were closely associated with the Jesuits first and later with the Quebec Seminary. Usually one of the priests of that Seminary was the spiritual and even the general adviser to the nuns. The Seminary, the Jesuits' College, the Ursulines, and the Hôtel-Dieu formed a sort of cooperative for buying goods in France. The books of accounts of the Seminary show surprising entries, with a quantity of feminine articles, which evidently were for the various Sisters, since the Seminary had very few female servants.

As soon as the new faculty of medicine began its teaching in 1854, the relations between the medical professors and the nursing sisters of the Hôtel-Dieu became more active. Clinics were established very early. The medical faculty and the Sisters have always worked in cooperation. As for training in nursing, the Sisters of the Hôtel-Dieu at first looked upon it as a very modern invention and maybe something dangerous for their traditions. Seven schools of nursing were affiliated with the university before the Hôtel-Dieu made its request for such an advantage, ten years after the first affiliation. Yet they entered that new field with determination. They accepted the idea of a higher course in nursing, which I proposed to them in 1933. The first lessons for that course were given at the Hôtel-Dieu in the winter of 1934 for some 20 Sisters of various orders. At the present time 15 schools of nursing are affiliated with Laval University for the basic course. Besides these schools, there are courses in surgery, obstetrics, and gynecology. All these teachings are controlled by the medical faculty and by some of the administrative officers of the university.

Though there would be much to say about the French Canadian nurses and the various professional associations of nurses, I shall refrain from making any comments, since there are in that matter very delicate problems and since it would require a pretty long development.

Most of the nurses present at this convention speak English and I presume they would like to know what the relations are between the university and English-speaking Canadians. These relations have always been very friendly. Even before the charter it was customary for the Quebec Seminary to register a good many English-speaking pupils. When the university began to give courses, young men of English language registered in law, in medicine and in arts, especially for pharmacy. Their proportion was about 25 per cent of the total registration. That practice has continued without interruption and it is now quite remarkable, especially for the summer courses. It is impossible to find in Laval University the slightest trace of narrow-mindedness in that field. This university is strongly in favor of the bi-cultural and of the bilingual system for Canada.

Recently in Quebec there was a conference where 50 university professors, all bilingual enough to understand each other in either language, met to discuss the same high problems from different angles. It has been said that such a conference was an "ideal little Canada" and the best means to promote national unity. Of course there is still a long way to go before we achieve a perfect understanding between the two major groups of Canada. There are still many prejudices to abate, but light will come—it is coming. The idea of a Canada with two cultures is gaining momentum.

Your association can take its part, and a leading one, in that splendid work. One goal might be for every member to be bilingual when, in your discussions and reports, either language may be used. Every educated Canadian, and you all are, should study the remaining prejudices that still prevent a true Bonne Entente.

Your immediate duty is to treat suffering humanity; but you are citizens of this country and as such you must contribute to the building of a great nation—the Canadian Nation.

Pleurisy

S. MARCUS, B.Sc., M.D., C.M., F.C.C.P.

Pleurisy or pleuritis is an inflammation of the pleura with or without a liquid effusion. It is a very common affection and may be either a primary or secondary condition. In most instances it is secondary to some other process.

Most cases of primary pleurisy, or so-called idiopathic pleurisy, have been demonstrated to be of tuberculous origin. Secondary pleurisy is usually due to extension of disease from the chest contents or through the blood stream and may be due to a variety of bacteriological agents.

Classification of the pleuritides: Acute fibrinous pleurisy (dry); serofibrinous pleurisy (wet); purulent pleurisy (empyema); hemorrhagic pleurisy; chyliform pleurisy; cystic and fungous infections.

MORBID ANATOMY

The area of pleural involvement may be limited to a small site or may involve a complete side. The apices of the lungs are most frequently involved although clinically it is diagnosed usually in the anterolateral portion of the lower part of the chest. Friction and pain are often found in this region. The inflammation may be limited to the pleura covering the diaphragm.

In *fibrinous pleurisy* a threadlike exudate forms on the pleural surfaces. This may ultimately disappear, although more commonly it undergoes fibrous changes, which produce adhesions between the visceral and parietal layers. At times the pleural space may become completely obliterated.

In *serous pleurisy* there is an outpouring of serous fluid that may vary from a few centimeters to several litres. The mechanism of its production is still the subject of much discussion. The fluid in serofibrinous pleurisy is yellowish and clear in color. It may be opalescent and contain flakes or coagulated masses of fibrin. Microscopically leukocytes and a few blood cells are noted.

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SYMPTOMS

Most cases begin with a sudden sharp pain in the side, with a chill followed by fever. The character of the pain is extremely variable. During the early period of the attack the picture is that of all acute infections—slight fever, headache, anorexia and, in addition, sharp pain, worse during respiration and cough. It may be agonizing in character. The respirations are rapid and shallow in dry pleurisy. The patient, by breathing in this manner, unconsciously tries to prevent the inflamed pleural surfaces from rubbing together. Cough is short and hacking. With the development of an effusion the pain disappears entirely or leaves only a feeling of soreness. The temperature may reach 102 - 103°, it may be continuous or remittent though it usually falls gradually by lysis. The pulse is usually 100 or over. Dyspnea is not marked if the effusion is insidious in onset. Nevertheless, diagnosis must not be casual.

DIAGNOSIS

Many cases of acute pleurisy with effusion escape notice. Primary fibrinous pleurisy should always be considered as tuberculous in character. It is a common symptom of the onset of pulmonary tuberculosis. The possible extension of this disease into the lung is important. Pleurisy with effusion is more closely related to tuberculosis than the fibrinous type. Acute lobar pneumonia that involves the surface of the lung gives rise to fibrinous pleurisy. Any disease of the lung that involves the surface may give rise to fibrinous pleurisy.

In pleurisy with effusion diagnostic thoracentesis should always be performed. The character of the fluid is important—bacteriological smears, cultures, and guinea pig inoculation should be made.

In the differential diagnosis we must exclude empyemata, pericarditis with effusion, pneumonia, chronic suppurative conditions in the lungs, intrathoracic tumors and cysts and, occasionally, liver and subphrenic abscesses and cysts.

Sequelae

If untreated, chronic pleurisy with effusion may persist for months and even years. Chronic dry pleurisy is not an uncommon sequela. Pulmonary fibrosis may occur in long-standing cases.

Treatment is that of any acute infection, plus symptomatic therapy such as fixation of the chest and sedation. With effusion repeated thoracentesis may be necessary.

Prognosis

Primary fibrinous pleurisy and pleurisy with effusion must be considered as tuberculous in origin until proved otherwise. The patient should be kept under observation and regular chest roentgenograms taken. It has been variously estimated that 35 to 50 per cent of patients with pulmonary tuberculosis give a preliminary history of some type of pleurisy.

The Nursing Care of Pleurisy

Martha Aldrich

Since pleurisy may be the first manifestation of pneumonia, a spreading tuberculosis, or pleurisy with effusion, the condition must be handled carefully. This is largely a matter of nursing care. Careful x-rays and sputum examinations are done to try and discover the underlying condition. Those patients with an apparently spontaneous fibrinous pleurisy should be treated with a view to prevent further development of any tuberculosis which may be present. Pleurisy with effusion sometimes begins as a fibrinous pleurisy but more often the onset is insidious and the patient may not even notice its presence. Empyema, also, often develops insidiously but the patient with this condition appears much sicker, has a higher fever, and becomes more anemic than one with an uninfected pleural effusion. More specialized nursing care is, therefore, required.

Bed rest is essential in all cases of pleurisy, at least as long as any fever is present. Temperature, pulse, and respiration are taken and recorded every four hours. This usually is a good indication of the patient's progress because as long as there is any infection present the temperature remains elevated. Immobilization of the affected side gives relief from pain and may be accomplished by using a tight binder or strapping with adhesive plaster, the latter being more satisfactory if it is convenient to use it. If something more is necessary to relieve the pain, sedatives, such as codeine or morphine, may be used.

Because of the pain caused by each respiration, the patient naturally takes the shallowest breaths possible. Sometimes a deficiency of oxygen results, with cyanosis. Then the use of oxygen, given by nasal catheter or tent, is indicated until the patient is able to maintain an efficient supply of oxygen himself. If he has a cough, which is usually short, painful, and non-productive, a bronchial sedative or expectorant is given with relief. The sputum, if any is produced, should be collected and examined to discover the particular organism which may be causing the infection. The patient should be impressed with the importance of rest even after the infection appears to have subsided.

The patient is kept as comfortable as possible by the practice of everyday good nursing procedures. A daily bath is essential, whether taken by the patient himself or given by the nurse, depending upon his condition. The patient with a high fever may require more bathing than just once daily. Frequent alcohol rubs add to his comfort. His position, although he prefers usually to lie on the affected side, should be changed from time to

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time. He is usually more comfortable with the head of the bed elevated and his back supported with pillows. Good oral hygiene is necessary as in all cases with a high fever. Regular elimination habits are maintained, either by the use of laxatives or an enema when necessary. The patient should be in a cool, bright, well ventilated room where a pleasant, cheerful, atmosphere is maintained by the nursing staff.

Those patients who develop a pleurisy with effusion require all the nursing care outlined in the preceding paragraphs plus additional procedures. The presence of fluid in the pleural cavity causes difficult respirations and considerable discomfort to the patient. Therefore sufficient fluid should be removed often enough to keep the patient comfortable. However, the fluid should be first examined and cultured. If it is found to be purulent, complete removal is considered.

Three methods of drainage have been commonly used: open drainage by rib resection; closed drainage through insertion of an airtight tubing opening under water; and repeated thoracentesis with aspiration of the exudate. In children aspiration often is sufficient. In some cases, repeated removal of the fluid through a needle and the instillation of penicillin into the pleural cavity has been successful. If, on culture, the causative organisms have been isolated other antibiotic substances, specific for treatment of these organisms, may be given orally or by intramuscular injection. Terramycin, aureomycin, and streptomycin have been used. Special attention must be paid to care of the skin around the drainage tubing, especially after each thoracentesis.

During convalescence, deep breathing and other exercises may be of value in helping in the reinflation of the lung previously collapsed by the pleural fluid.

The diet is an important feature in the nursing care of patients with pleurisy. During the acute stage when the patient does not feel like eating, easily digestible fluids with a high caloric content are given as often and in such quantity as the patient can tolerate. The nurse may have to insist upon his taking something, because in this condition he will not take enough voluntarily. As his condition improves, so does his appetite. The diet is increased from fluids to soft and gradually to full. In some cases, especially those of pleurisy with effusion, the patient may be weak, underweight, and anemic. Symptoms should be treated, as indicated, with dietary supplements, digestive stimulants, cod liver oil, iron and vitamins, in whatever form the doctor prescribes.

More is needed than just good nursing care while the patient is in the hospital. While giving this regular care the nurse has a wonderful opportunity to teach the patient the importance of rest and good health habits, especially during convalescence and after he has recovered completely. It is well to remember that "an ounce of prevention is worth a pound of cure."

The Oldest Known Will

Translation of Will of Uah—an Egyptian—made in 2,548 B.C., 4,500 years ago.

"I, Uah, am giving a title to property to my wife Sheftu, the woman of Gesab, who is called Teta, the daughter of Sat Sepdu, of all things given to me by my brother Ankh-ren. She shall give it to any she desires of her children she bears me.

I am giving to her the Eastern slaves, 4 persons, that my brother Ankh-ren gave me. She shall give them to whomsoever she will of her children.

As to my tomb, let me be buried in it with my wife alone.

Moreover as to the house built for me by my brother Ankh-ren, my wife shall dwell therein without allowing her to be put forth on the ground by any person.

It is the deputy Gebu who shall act as guardian of my son.

Done in the presence of these witnesses:
Kemen, Decorator of Columns,
Apu, Doorkeeper of the Temple,
Senb, Son of Senb, Doorkeeper of the Temple."

The Patient's Point of View

PATRICIA JONES

Going into hospital for an operation is an unnerving proposition, however you look at it. Getting undressed and climbing into a strange, and unnaturally high, bed in the middle of the day; wrestling with the intricacies of a hospital nightgown that opens, with no regard to modesty, right down the back, and is far too short; submitting to having your pulse taken while a thermometer is thrust into your mouth; obeying the orders of a crisply dressed nurse; anticipating with mixed feelings the visit of your doctor—that competent impressive person who holds your destiny in his hands. Maybe you have been planning this operation for some time so that your affairs are all in order, your suitcase appropriately stocked with necessities, your will signed and in the hands of your lawyer. More likely this is an emergency, a sudden illness that has snatched you from the middle of a myriad of affairs and you are totally unprepared.

In either event, hospitalization is traumatic. It is not to be confused with humdrum events like going to your work or attending a movie. The hospital itself is impressive. It is a place of life and death, of healing and of pain. For the time you are there you must, perforce, regress to childhood and be dependent—in the most intimate matters — on strangers. You must submit to the indignities of enemas, bed-pans, bed-baths, perhaps shaving of hair on various parts of the body. All these strange proceedings, accepted so calmly by the nurses, have enormous importance to you, the patient, and attain something of the quality of mystic rites. You wonder, uneasily, if you are being prepared for death. The amazing assortment of garments that custom decrees necessary for the operating theatre—the white stockings, white turban and sheet—add a bizarre note that heightens tension.

Miss Jones is not a nurse so her observations of what it is like to be the patient give us some constructive suggestions.

In the hospital you are in a new world. You, the patient, are stripped of the dignity built so laboriously in home or business. You have a new status. You are the patient—at once the most important and the least important person there. Without you the hospital would not exist. For your benefit, doctors, nurses, social workers, laboratory technicians, and a dozen more professional groups have studied and toiled for years to attain more and wider skills. You are the centre of interest—the focal point of trained teamwork. Your physical reactions are of enormous importance. Your intake and output are carefully charted. Your medication is thoughtfully planned. Yet, in the hierarchy of the hospital, where the doctor is king, you are expected to submerge your individuality, meekly obey orders, submit without complaint to treatments, cease to use your trained intelligence. Your enquiries into the reason for certain procedures, or the type of medication you are ordered to take, are treated coldly. You are "the patient" and, as such, are expected to have a childlike faith in the infallibility of doctor and nurse. The "what" and the "why" are not your business.

Let us be frank. They are usually right—these determinedly professional people. You have confidence in them and you are sure their training has been thorough. They are unfailingly kind and thoughtful. They know all sorts of tricks to make you comfortable. Their whole interest is in your physical well-being and they do a wonderful job. Your only real complaints are that they do not always recognize the uniqueness of the experience *you* are undergoing; and they seldom choose to treat you as a person of equal intelligence, one who has the capacity and, indeed, the right to share in the teamwork being undertaken on your behalf.

The doctor, often working 12 or 14 hours a day, usually is too rushed to spare more than a passing thought for the emotional strain you may be undergoing. The nurses hurry to and fro,

striving to remember the myriad details of care required by each patient. Is it any wonder that your personal reactions are ignored or overlooked? Yet something of real importance is being passed over. There are emotional scars in the making, deep wounds that may fester if they are not tended.

Take, for example, an eye operation. There are a lot of them done these days—wonderful operations that save sight. With minute instruments, the doctor works patiently on one small area of an eye and performs miracles. But how often does he see the necessity of preparing you emotionally for post-operative care? If he is a good doctor—and most of them are—he will describe in advance and in layman's terms what he plans to do in the operation, outlining the risks involved and the probable results. All too often he forgets to prepare you for temporary blindness—for that big wad of cotton that will cover *both* eyes for several days. It has probably become a commonplace to him, so inevitable a procedure that he does not give it a second thought. When the bandage goes on—and you protest—then the doctor will probably explain that it is the only way to rest the eye and keep it from moving. He would have saved you an unnecessary shock if he had told you about it in advance. You would have been emotionally prepared. You might also have made sure you had a radio to comfort your loneliness in the darkness and perhaps friends to visit you.

You also need preparation for post-operative pain. Operations are so strange to you that you do not always anticipate such things. When the anesthetic wears off and you feel a thousand little devils stabbing you with knives, you are apt to imagine that "something has gone wrong." If the doctor explains, in advance, that the stitches may pull as the eye swells and retracts, then fear is banished and the pain is accepted as a necessary evil that is unpleasant but not alarming.

The blindfold plunges you into darkness. It is an abnormal situation that awakens primitive fears. You do not realize how much you have depended on your sight until you are deprived of it. You cling, precariously, to reality. Your doctor has told you—and you believe him—that this is a temporary measure. Your present blindness, you tell yourself, is not a tragedy but merely an embarrassment. You try to find the funny side of it, to joke over your fumblings. It is not too easy. You are chagrined when you inadvertently knock over a vase of flowers or smash your feeder. You break into a cold sweat when you cannot locate the bell to call the nurse. Lying flat on your back in bed, you seem to float in space. The walls of your room no longer exist. Your ears strain in an effort to replace your eyes. You hear rustles, murmurs, creaks that you cannot identify. You wonder whether you are alone or whether people are walking about near you. The darkness begins to ripple as panic rises. It breaks into waves, explodes into light flashes, stars, strange shapes and faces. You are unable to shut out this weird assortment of "long-leggedy beasties" that is tormenting you. Your body is tense—your breath comes fast. For a short time you may even be disoriented.

There are some simple ways of keeping panic at bay but these require the help of hospital personnel. You can quickly learn to "see" with your fingers. On your bedside table, within easy reach, can be placed paper handkerchiefs, candy, toilet water, feeder and so on. The maid, when dusting, should take care to return each object to its exact position and you can check them before she leaves the room. The radio can also be within easy reach of your hand, so that you can turn it off or on at will. This gives you a measure of independence that is very precious.

People entering your room, or approaching your bed in the ward, will help you a lot if they announce themselves. In the workaday world you are accustomed to recognizing friends by their appearance. When you are blindfolded you must depend on your memory of their voices. It is embarrassing to both you and your visitor if you make a mistake. This applies to the doctor, too. It is customary for him to enter with a nurse or, perhaps, other doctors. It is disconcerting, to say the least, when you and your doctor begin to talk privately—or so you imagine—then you hear a shuffle of feet or a rustle of starched

uniform and discover that you have an audience. It would be comforting if the doctor said, "Good morning, I'm Dr. X. I have Dr. Y with me and Miss Q is here, too, to assist me with the dressings." You know where you are then. It helps, too, if the doctor takes your hand when he speaks. A handclasp is an additional method of communication, compensating to some extent for that facial expression of interest in your welfare that you cannot see.

Conversely, it is important for you to know when people leave the room. You can get quite a nasty "turn" if you have been chatting to the nurse as she moves about your room. For some reason she has occasion to leave, but you don't realize this since she moves silently in her rubber-soled shoes. The breeze blows the window curtains, sounding like the rustle of the nurse's uniform, so you speak to her. She doesn't answer. You speak louder, alarm mounting. Your imagination plays tricks as you listen intently, trying to figure out what she is doing. She could have saved you some bad moments if she had mentioned that she was leaving the room.

There is another point that causes you amusement and sometimes annoyance or strain. People shout at you. You may have caught yourself in the same error when talking to someone who does not understand English. You talk more loudly! Even nurses fall into this error, sometimes, when talking to you while you are blindfolded. They imagine you cannot hear either. Actually, nothing could be further from the truth. Unless you are hard of hearing, your ears are more alert when your eyes are covered. You catch the softest whisper and are particularly aware of nuances of tone. Fatigue, irritability, boredom—they stand out like sore thumbs in the tones of voice. Conversely, it is wonderfully comforting to be greeted by a warm friendly voice when you ring for a nurse—to be assured that "it is no trouble at all" to answer your enquiries as to whether it is night or morning or some other apparently trivial matter.

The nurse who has sufficient imagination to realize the uniqueness of your present experience is quick to realize how important it is for you to cling to reality. When she comes into your room to fix a flapping window shade and you remark that you have had a good night's sleep, she helps you to see the funny side of things as she explains, with a chuckle, that it is only 2:00 a.m. so maybe you could manage another "forty winks" before breakfast. If you cannot doze off again—and the nights are extra long in your situation—she may be imaginative enough to anticipate your needs and bring you, unasked, some tea and toast, hot milk or a sedative. You appreciate that very much because you hate to be dependent in every area and have to "ask."

It helps, too, if the nurse is not too hidebound by regulations, if she recognizes you as a person and not just one of the patients assigned to her care. There are times when the usual sponging of hands and face and plumping up of pillows will do nothing to add to your comfort. One of those times is when you have just got over a bad bout of pain and are relaxed, fearful of moving a muscle, in case the pain should recur. You don't even want to talk. Drowsy with sedation, you long to be left alone. The bright cheery nurse, bustling in with a bowl of hot water, and full of desire to wash and powder your back, is someone you resist viciously. You snap angrily at her.

Another time that you may resent her is after a particularly bad night, when you have finally fallen asleep and she awakens you with a snap of the window blind and a flick of the thermometer at least half an hour before your breakfast is due. Poor nurse! In your saner moments you realize that she may easily be unaware of your "bad times" and thus can hardly be blamed for carrying out her busy schedule with as much despatch as possible.

The healing process that is so important during those days and nights of imposed darkness is quickened when you have peace of mind. It is slowed down if you are tense, anxious, confused. If your illness has struck suddenly, you may have a myriad of worries with which you need help. Neither doctor nor nurse can help you here. Many hospitals make available to you the assistance of the trained medical social worker, regardless of your financial status. You can feel comfortable with her. She does not hurry and you

know, because your doctor has told you, that she will treat your affairs as confidential, sharing them only with him and the head nurse. She seems to understand, without your having to put it into words, the strange fears you are experiencing. She is interested in learning how your illness affects you personally. She is prepared to attend to intimate matters concerning your personal affairs or your family with the minimum of fuss. You realize also that she is handling effectively that "emotional component" that is an important part of your illness and that your doctor has told you must be solved if you are to return to full health.

You find, however, that it is sometimes hard for you and your social worker to establish a good working relationship when you cannot see her. You wish to goodness she had seen fit to make your acquaintance *before* the operation instead of waiting until you are plunged into darkness. You wish, too, that she would remember to tell you that you and she are talking privately, without onlookers, when she drops in to see you. You would feel more comfortable about speaking freely to her.

The dietitian has an important part to play in helping you during your "dark days." It is so humiliating to be fed—and quite unnecessary as a rule. Food seems to taste so much better when it reaches your mouth at the moment you expect it. You can have some interesting discussions with the dietitian as to the food you are permitted and ways it can be prepared so that you can handle it. Even though you must lie flat on your back, a bib can be draped round your neck and chest to catch the splashes. Salads can be prepared so that lettuce, celery, tomato slices, and chicken can be handled in the fingers. Moist meat and vegetables can be cut up so that you can handle them in a spoon, with a cracker in the other hand as a pusher. Liquids can go in a feeder. Mealtimes then become a pleasure instead of an ordeal.

Visitors are generally good for morale but you do wish there was some way of weeding out the ones who overwhelm you with sympathy or, conversely, depress and tire you with long recitals of their own woes. In the main, however, it is a wonderful help to "see" your friends, especially if they come prepared to read aloud or keep you entertained with news of mutual friends. One visitor at a time is usually more comfortable than several at once. It is exasperating when they bring you lovely flowers that you cannot see, except maybe for one brief moment when the bandages are being changed. Flowers are friendly things in a hospital ward, however, and "the thought behind them" brings you a warm feeling.

When you have had a good day and are feeling relaxed and comfortable, a strange thing happens. You have a sense of sight. All at once you are aware of light shining through the bandages. You know who is around you and are able to follow their movements round your bed as though you could see them. You chat and laugh, you are at peace with the world, and you can almost sense the healing process going forward at top speed.

Soon it will be time for the bandages to come off for good and for your doctor to talk in terms of discharge date. Surprisingly enough, you are not too enthusiastic over the prospect of leaving the hospital. The uniqueness of your experience has gradually diminished. You have become reconciled to your status of "patient" and are almost fearful of resuming your former responsibilities in the outside world.

Volunteer Societies

Democratic countries do well to encourage the voluntary societies in the field of health because citizens, associated in committees to work for the common good with no thought but the good of the community, can do work cheaply and effectively. It should be obvious that citizens organized to protect themselves and their children will work with an enthusiasm which cannot be duplicated by any form of organization to be found in a totalitarian atmosphere where their activities are discouraged.—Dr. Gordon Bates.

Air-Borne Allergens

C. H. A. WALTON, M.Sc., M.D., F.A.C.P.

An allergen must enter the body before an allergic reaction can take place. There are several routes of entry. The allergen may be swallowed or ingested, such as food or drink or medicine. It may be injected as with medications, such as insulin, liver, penicillin, etc. It may enter the body through the skin as in the case of contact dermatitis. Finally, the allergen may enter the body through the respiratory tract.

To be inhaled the substance must be suspended in the air in the form of dust particles. A dust particle cannot enter the respiratory tract unless it is air-borne so that it reaches the nose or the lung in a current of air. The dust particle comes to rest in some part of the respiratory mucosa. There it undergoes an aqueous form of extraction. The aqueous extract is absorbed through the mucosa and may affect the cells directly if they are sensitized or it may travel *via* the body fluids to other tissues. If such other tissues are sensitized a reaction will occur there. The site of the reaction depends on the location of the sensitized cells and it is not necessarily related to the route of entry of the allergen. The allergen may enter the nose and cause a reaction in the nasal mucosa. It may enter the lung and do likewise in the bronchial mucosa but it may also enter the lung and circulate and reach such an organ as the skin, leading to dermatitis.

I would like to emphasize the obvious point that the dust particles must be air-borne before it is possible for them to enter the respiratory tract. As these dust particles are inanimate bodies it is apparent that they will become air-borne only in the presence of a current of air. In perfectly still air dust settles and is not air-borne. In air which is greatly agitated the dust becomes air-borne readily.

Air-borne allergens are among the commonest of all and come from a great variety of sources. As they are commonly invisible, except in a beam of strong light, most of us are unaware that we are constantly breathing, in and out of our respiratory tracts, a great variety of very numerous dust particles. These particles are ordinarily innocuous—that is to say, they are not toxic. However, many of them have the property of becoming allergens to sensitive people. No doubt there are many dust particles which we have yet to recognize but, fortunately, for practical purposes we know the origin and properties of many and their effects on individuals who are sensitive to them. If these properties are known much can be done to recognize the source of the patient's trouble and, therefore, how to deal with it.

Seventy-five years ago Blackley in London demonstrated that he, and various other people like himself, suffered from hay fever and asthma during the season of grass pollination. He demonstrated conclusively that he had symptoms only when grass pollen was in the air. He demonstrated the grass pollen floating in the air and he estimated its quantity. He showed that it was in the air only when grass was actually pollinating in June and early July. He also demonstrated that if grass pollen saved from a previous season was placed in his nose or inhaled into his lung in some other season symptoms were produced. Finally he demonstrated that if grass pollen was scratched into his skin, that an urticarial wheal resulted.

This is the classical demonstration of air-borne allergy. Since his time we have learned that the pollen of many plants is allergenic and that it does, indeed, cause symptoms of hay fever, asthma, and some cases of dermatitis in many individuals. It is obvious that such pollen must be air-borne before it can reach the patient. Thus only plants which can produce air-borne pollen are of importance in allergy. Many plants, particularly those with bright flowers, are insect pollinated. Their pollen is too large and

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sticky and too heavy to be readily air-borne. Such plants are not important in allergy. The rose and the goldenrod are myths in allergy. Plants with small, inconspicuous, ugly and badly scented flowers do not attract the insects and, therefore, to achieve cross pollination they must produce large quantities of small, dry, light pollen grains which float in clouds in the air and thus reach other plants. These are the plants which concern us.

Tree Pollens

These plants may be divided into three groups: the trees, the grasses, and the weeds. Such trees as the poplar, willow, elm, maple, ash, alder, and the oak commence pollination usually rather suddenly in late April and continue to pollinate into May. These dates, of course, vary in different latitudes and in different areas. It is obvious that if a patient is sensitive to the pollen of any of these trees he will develop symptoms only when that pollen is in the air and can reach him.

Grass Pollens

The next item in the pollination calendar is the flowering of the various grasses. Generally this starts early in June and increases in intensity into the early part of July but many species continue to pollinate, though not heavily, throughout the summer. The amount of pollination, of course, varies greatly with climatic conditions. Grass pollen is thin-shelled and absorbs moisture very easily. If there is much rain or humidity grass pollen grains absorb moisture, become heavy and fall rapidly to the ground where they are harmless. In a hot, dry summer, if growth has previously been good, pollination is heavy and bothers the patient a great deal.

Weed Pollens

In the great plains of North America and throughout the eastern part of the continent, the next pollen season is that of the weeds. Generally this season starts at the end of July and extends through August into September. The weed pollen sensitive case suffers his trouble in the weed pollinating season. If he has the good fortune to be in an area where weed pollen does not exist, he will, of course, have no symptoms. In large areas of this continent one hears a great deal about ragweed pollinosis. Some three-quarters of the populated area of the continent suffers to a greater or lesser degree from ragweed.

This, in brief, is the story of pollinosis. Do not worry about the brightly flowered plants or the brilliantly flowered trees because they cause no trouble. The beautifully flowered lilac attracts attention in June but it is the inconspicuous blossoming grass around about it that in reality causes such misery to the patient.

Fungi

There is another group of air-borne allergens which has some seasonal characteristics and which is somewhat analogous to pollen. These are the spores and cells of fungi or moulds. Any study of the atmosphere will demonstrate dozens of fungus spores. These vary greatly in each area and depend on local characteristics. There are some fungi which produce spores in varying quantities throughout the year, irrespective of the temperature or other atmospheric conditions. Such fungi are found outside and also inside buildings. I refer to this group of fungi as the perennial type and it includes such common moulds as yeast, penicillin, aspergillus, rhizopus, mucor, monilia, etc. All of these can be identified and counted in air studies and this is done quite simply by the exposure of suitable culture plates.

There are a number of other fungi which are characteristically seasonal. These seasonal fungi are found thriving after the snow has gone in early spring and they persist in large quantity until they are heavily blanketed with snow in the late fall. During winters in which there is very little snow, small numbers of them survive and throw off a few spores throughout even the coldest months but, in general, they only appear in significant amounts in the air in early April, gradually increasing throughout the summer and reaching their height in late September or October, long after the last pollen grain has left the air. The three common examples of this seasonal group are alternaria, hormodendrum, and helminthosporium. In addition, in agri-

cultural areas we find the spores of rust and smut. Such parasitic spores are very widespread and dense but their season is very short. Rust and smut can be allergenic and are demonstrated in a few cases but the other seasonal spores cause the greatest number of allergic reactions and are comparable in their effect to pollen, such as ragweed. The perennial spores also seem to be important, though less strikingly so than the seasonal ones, and they occur under many circumstances. Exacerbations occur under special circumstances such as the cleaning out of a mouldy basement, the opening of a summer home, etc.

Insect Scales

The third type of seasonal air-borne allergens is represented by the scales from insects. While physical allergy to these substances is not common, it does occur in a very severe form under some circumstances. We have an insect, known as the May Fly, which occurs along rivers which are rapidly flowing. This fly collects in great quantities in such places as power houses, so that in a sense it represents an occupational hazard and the employees of hydro-electric plants are apt to show sensitivity to these insects and their scales.

Most of the other dusts occur throughout the year and are not seasonal in the ordinary sense of that term. There are certain seasonal characteristics for these dusts in that during the colder months of the year they are more troublesome because the habitations, barns, and workshops are closed up for warmth and the dust concentration becomes higher in the confined, slightly ventilated space. Thus a patient who is sensitive to the family cat may be very much better in the summer when the animal is out more and when his house is more open—that is, the dust density of cat dander in the air at home is less.

Animal Dander

Haired animals are a great source of allergenic dust and obviously those animals with which man is most intimately associated are the worst offenders. Cats and dogs, which are so common as household pets, produce great quantities of dander. This dander becomes an integral part of the house dust. Whether the animal is in evidence at any particular moment or not, his dust is in the air and the sensitive person inhaling it will manifest symptoms. No animal should ever be permitted in the home of an allergic patient, whether or not sensitivity has been demonstrated. It is well to remember that, apart from these two pets, families very often have unexpected pets such as rabbits, rats, hamsters, and so on. Even the old cowhide rug or the bearskin, so proudly won hunting, may be a source of trouble. There is much joking about the human animal and his dandruff and whether one can become sensitive to it. Ordinarily this is a small problem but it is perhaps of some importance among hairdressers and barbers. Apart from pets, animals on the farm, or in other establishments where they may be kept, are of great importance. Cows, horses, animals in a circus, a zoo or a riding academy are all important sources of dander and all cause a great deal of trouble.

Bird Scales

Birds are another source of dust. The scales from their feathers are highly allergenic. A pet bird or birds in a poultry house or finally, of course the most important of all, the feathers in our pillows, in our eiderdowns, and even in our mattresses are a great source of trouble. The allergic child or the child of an allergic parent should not be introduced to a pillow. If he doesn't become accustomed to one he will never miss it and he may be protected from a very troublesome allergy later in life. If he must have a pillow, make it of sponge rubber.

Domestic Dust

There are certain domestic dusts which are of great importance. House dust is a mixture of many things—textile dust, such as cotton lint, the lint from wool; the dust from special forms of mattresses; from bathpowder, from insecticides used to kill moths, particularly pyrethrum, and finally the dust from tobacco. Such dust is remarkably uniform allergenically from house to house. It is a very potent allergen and is a great source of trouble to many patients.

Occupational Dust

There are many occupational dusts. In my section of the country grain dust is of the greatest importance. Farmers, elevator operators, and other employees of the grain trade are very common sufferers from respiratory and skin allergy due to sensitivity to this very potent allergen. The dust from seed, old granaries and from feed, particularly crushed feed, is related to and very much like grain dust. Another occupational dust, perhaps somewhat related, is flour dust. The dust which the miller and the baker inhale when carrying out their normal duties may be the cause of much asthma, rhinitis or dermatitis. An occupational dust of great importance is fur dust—the dust which occurs in the establishment of furriers. Still another is that which arises from set or hair-wave lotions. Hairdressers are peculiarly prone to this form of sensitivity and it is also seen, of course, among women who are not hairdressers but who work on their own hair and that of their friends. The basis of this particular dust is vegetable gum such as tragacanth, karaya and gum arabic. People who are highly sensitive to fish may develop symptoms if fish is in the same room. Workers in the fish industry are inclined to suffer this way. Much glue used commercially comes from fish. Dried glue forming a dust is a very potent allergen. Today plastic and other substances are replacing fish glue to some extent and perhaps this particular allergen will become less important.

Specific Management of Inhalant Sensitivity

If one accepts as a clinical fact that various air-borne dusts can cause many cases of respiratory allergy, some cases of skin allergy, and perhaps even a few cases of migraine, knowing their properties aids one in making a diagnosis. Diagnosis can be aided by carrying out skin tests. Fortunately, skin tests are highly specific and quite valuable in the diagnosis of inhalant allergy. Generally speaking, skin tests are very simple. If the suspected dust is rubbed into a superficial scratch and perhaps moistened by some agent — tenth normal sodium hydroxide—a reaction will occur if the skin cells of the patient are sensitive. The reaction consists of an erythematous flare surrounding an irregular urticarial wheal. The more sensitive the skin the more irregular and large the wheal and/or the erythema. This reaction is accompanied by considerable itching. Such a test is described as "the scratch test."

Skin Test

The scratch technique is still the best and certainly the safest way of carrying out skin tests. Given a reasonably pure sample of the dust, there is no problem in carrying out tests. For convenience sake, the commercial houses now prepare extracts of the dusts. These are a little simpler to handle, probably less troublesome and expensive, and are equally good. The only difference in technique is that the extract is rubbed into the scratch in the skin rather than the dry dust. A positive reaction, of course, means only that the skin or dermal cells are sensitized. Fortunately, in inhalant allergy this indicates, in the vast majority of cases, that the nasal and bronchial mucosa are also sensitive. However, false reactions may occur—that is, the patient may suffer from animal dander sensitivity and yet his skin may not react to it. On the other hand, positive skin tests may occur without clinical manifestations.

Direct Test

The only test which is really acceptable is a direct test. If the patient is subject to hay fever it should be possible to reproduce the hay fever by planting the suspected pollen on the nasal mucosa. If no reaction occurs the suspicion is obviously ill-founded. Similar tests are done on the conjunctiva or by inhaling the dust, in the form of an aerosol, directly into the lung. Obviously such tests are usually impractical because of their inconvenience and because most patients would refuse to submit to them. Luckily, the skin test is more convenient but must not be accepted blindly and only with a knowledge of its limitations.

Negative skin tests do not mean that the patient is not allergic. They simply mean that his skin cells are not sensitive to the agents tested. His respiratory mucosal cells might still be sensitive. Nothing is more tragic than to tell a mother that her boy does not react to dog

dander by skin and, therefore, that he may keep the dog when the dog might well be causing much of his trouble.

Intracutaneous Test

Another form of skin test often used is the intracutaneous test. This is carried out by injecting an extract of the suspected dust into the dermal layers of the skin and the subsequent reaction is similar to that produced by a scratch test. This test is more delicate but it is also more dangerous and false reactions are more apt to occur. In the hands of the experienced doctor the intradermal test is valuable but there can be little or no excuse for it when it is used occasionally and is apt to do more harm than good.

Skin tests are only useful as an aid to diagnosis and are not a diagnosis in themselves. A patient should not be given a list of skin reactions to carry around with him any more than a list of his blood sugars, blood urea nitrogens, or other laboratory tests. He cannot interpret them and he nearly always gets into trouble with them. A careful history and a knowledge of the patient's environment are the most important factors in diagnosis. Skin tests serve to supplement these diagnostic measures and are not diagnostic in themselves. The misuse of skin tests has probably done more to put clinical allergy into disrepute than any other factor.

Treatment

Once a diagnosis has been accurately made, the proper treatment is to attempt to separate the patient from the offending agent if this is possible. It is obvious that the ragweed patient cannot be separated from the ragweed pollen during August and September unless he goes to some place where ragweed does not exist. This is obviously impractical in most instances. However, if the patient is sensitive to cat dander it is perfectly clear that it would be much better for him to part with his cat and clean the house out thoroughly than to undergo desensitization for the rest of his life or, at least, for the rest of the life of the cat. In general, it is possible and practical to separate the patient from his offending agent when that agent arises from animals, birds, cosmetics, tobacco, insecticides, etc.

Sometimes, of course, the patient's livelihood depends on him remaining in his unfavorable environment. The average farmer is not able to leave his farm, particularly in the harvest season. Such a patient must have other protection. The engineer who has spent his whole professional life in a hydro-electric plant obviously is unable readily to move to another and strange job. The operator of a grain elevator may have no other training and needs to stay with his job at all costs. Similarly with the furrier, the hairdresser, the fish worker, or the miller. All these are highly specialized trades and it is rare that one can separate the victim from his trouble. In all instances where it is impossible to separate the patient from his allergens, the method of treatment is to offer him desensitization or, more correctly, hyposensitization.

Hyposensitization

Briefly, this is carried out by making an extract of the offending material with physiological saline and injecting tiny amounts of this into the patient subcutaneously. These amounts are gradually increased as the patient is able to tolerate them and, in many instances, a remarkably effective immunity results. Generally speaking, desensitization to animal dander is sometimes effective. Often the treatment carries an element of danger and it should only be used when no other method is available. Feathers are seldom of use in desensitization and avoidance is the only solution. Obviously, house dust itself cannot be avoided, although it can be mitigated. Substances such as pyrethrum are better not used for desensitization. Desensitization to grain dust is very effective. Fish dust and glue dust are much too dangerous to use. Flour and other cereal dust cannot effectively be made into suitable solutions for desensitizing. The vegetable gums are also unsuitable and the hairdresser had best find another occupation.

Desensitization is an effective procedure in selected cases. Unfortunately, it is not permanent but has to be continued for many years. It must be done carefully because if too large a dose is given a very grave general reaction, and even a fatality, may occur. If too small amounts are given protection is poor. A conscien-

tious doctor who carries out a desensitization program very carefully will often be rewarded with good protection for his patient. Ingenuity, of course, will suggest the use of a rubber pillow and other protective devices to help the patient. Grain elevator operators, even with desensitization, find they must wear a mask when the dust density is great. A pollen sensitive patient should not go to the country at the height of his pollen season. The housewife will learn new methods to keep dust down — perhaps she will use a vacuum cleaner with a water bath dust collector. Suitable cosmetics are available for allergic women. The bird fancier must deny himself the luxury of pets in his home.

Inhalant allergy is common. Diagnosis must be specific. With an accurate etiological diagnosis treatment will readily suggest itself and will be most satisfactory to both the doctor and the patient.

Action in a Catastrophe

MAY G. DOUGLAS

The Jasper Chapter of the Alberta Association of Registered Nurses was organized in November, 1949, and consists of a small group of housewives who are graduates from accredited schools of nursing. Some of us graduated as far back as 1910, others as recently as 1949. Inasmuch as we left the field of active nursing to marry and raise families, we are sometimes termed "wastage" by the profession. We rather resent this term. We are still nurses, actively interested in nursing, who feel that through organization we can further the cause of nurses and nursing in the outlying areas.

The Jasper Chapter holds monthly meetings in the homes of its members who, held together by the common bond of nursing, rarely miss a meeting. The meetings are interesting as well as social. Speakers and films keep the members informed of new developments in the constantly changing field of medicine. The chapter does not, however, concern itself only with personal topics. Our community, to which we feel a deep moral obligation, is without public health services. Our sense of obligation, as nurses, prompts us to try to remedy this situation. Acting on the theory that the Public Health Department helps those who first of all help themselves, we operate a well-baby clinic once a month. We also provide, free of charge, a service to care for the newborn in the home. We often feel inadequate and look forward to the day when the proper authorities assume the responsibility of these public services.

Two members of the Jasper Chapter had the privilege of attending the lectures on A.B.C. Warfare in Edmonton. The duty assumed in accepting this course was to pass the information acquired to the other chapter members. This was done and the tuition was received gratefully by all members.

Nurses across Canada who have taken the course will be interested in comparing the teachings of Civil Defence nursing with what is actually applicable in a local disaster. The behavior of the Jasper nurses at the Canoe River train wreck highlights many points expounded in the Defence course for nurses. Supervision of untrained personnel, improvisation of supplies, and teamwork are stressed. First and foremost comes the duty of the nurse to her profession, to her patient, and to her community. Below I have outlined the facts of our part in the Canoe River wreck. It is interesting, indeed, to follow the pattern of Civil Defence nursing which appears again and again throughout this anecdote:

> At 11:30 a.m. on November 21, 1950, there came a loud knock on the door and the doctor's voice called, "There's been a wreck west of here. Dress warmly and

get to the station inside half an hour. We're sending out a hospital train."

I paused, startled, with a pan of eggs in my hand, the makings of my first-grader's lunch. A wreck! Words that spell panic and dread in a railroad town where most of the women are railroad wives. I calculated quickly. Could it be my husband? Could it be my friend's husband?

Thinking furiously, I went out the back door, pan of eggs still in hand, and called over to my neighbor. Would she take my child? There had been a wreck. She would—willingly. I handed her the pan of eggs and headed for another neighbor. Would she stoke my fires? I was needed to go to a wreck. She agreed to tend my fires. I was free—I ran home, dressed warmly in ski slacks and parka, threw a few toilet articles in a bag along with my hypo syringe and was off to the station before 15 minutes had passed. At the station were seven other nurses, housewives like myself. After comparing notes, we found that the above scene had been enacted in each home. Husbands, children, dogs, cats, and furnaces had been hastily provided for, mainly through the kind help of willing neighbors. By twelve o'clock noon, the hospital train, staffed by two Jasper doctors and eight Jasper nurses, was on its way to the scene of disaster.

The accident occurred at Canoe River, B.C., at 10:30 a.m., when a westbound troop train collided head on with an eastbound passenger train. The wreck, which is rated as one of the worst in the history of Canadian railroading, happened in a completely isolated area in sub-zero weather complicated by blizzard conditions. Engineers and firemen of both trains were killed instantly and their engines were reduced to a great pile of twisted steel. The baggage and mail cars of the passenger train were damaged but the coaches and passengers were relatively unharmed. The brunt of the collision was borne by the troop train, carrying hundreds of young untrained soldiers to American training camps. The front cars of the trooper were flung into the air and splintered like match wood. Steam lines were broken, heavy fixtures were torn loose, glass was shattered and fire broke out. In this snow-covered mountainous region, 21 people lost their lives and at least 64 persons were injured, 22 of whom were in serious condition.

Communications had been such that we were ignorant of important details. We had no knowledge of the gravity of the accident, the number of wounded, or the types of injury. During the 83-mile trip from Jasper to Canoe River, we made what preparations we could. Supplies were appraised, we tore linen for bandages and slings, and ampoules of morphine, coramine, and adrenalin were pocketed. We boiled up our syringes and needles on the caboose stove, laid out jars of sulfa cream, and prepared splints in readiness. After we had completed our arrangements, the conductor of our train made and served us coffee and a portion of his own lunch. We fell upon this with great gusto for we had missed our meal. It was many hours before we saw food again.

When we reached the scene, two and a half hours later, we found that all the injured had been removed from the debris and had been placed in the berths of the undamaged coaches. The dining-car was being used as an emergency hospital with the seriously injured on army cots. This proved a wonderful arrangement for the cooking ranges in the diners provided the only heat in the entire train. We had reason to bless these coal ranges and the staffs of the dining-cars before our mission was completed. A doctor from Edson, Alberta, who had been a passenger on the transcontinental train, had taken charge of first aid and had accomplished miracles in view of the fact that he had no supplies with which to work.

We went to work immediately and never were frightened young soldiers more grateful to have women relieve them of their arduous tasks! These same young men placed themselves at our service—to fetch and carry, to watch over their comrades and to call us when changes occurred. They took instructions like seasoned veterans and without their help our task would have been much harder.

We automatically paired off in teams—two nurses to a coach, each nurse with her two volunteer soldiers. Our first con-

cern was to combat shock and control pain. This we did as quickly as possible after the doctor's first cursory examination and his *carte blanche* to give sedation where needed. Although there was no hysteria, many of the men were shocked and frightened. They needed smiles and reassurance. These we gave and morale and spirits rose. We worked quickly from patient to patient, giving priority to the most serious cases. We found an amazing multiplicity of injuries. Extensive steam burns were complicated by powderings of fine ground glass upon the denuded tissue. Fractures were accompanied by more steam burns. Puncture wounds, lacerations, crushing and internal injuries vied with one another for priority. There was hardly a case with only one type of trauma.

We worked without ceasing. Our supplies were limited and, when we exhausted them, we improvised. We ripped table linen for bandages and dressings, when the sulfa cream gave out we made our own from ground tablets and lard from the diner. We filled bottles and tins with hot water for external heat for the men. We were without heat for nine hours and the temperature outdoors was 17° below zero. The nurses suffered from the intense cold but we managed to keep the patients warm, thanks to the wonderful cooperation of the cooks and stewards who kept their fires raging and willingly found and filled containers for us. We used tins and bottles for urinals. Our intravenous sets hung from coathangers. We used milk jugs for feeders. Too numerous to mention are the small innovations we evolved for the comfort of our patients. Slowly but surely out of the chaos came order. We were able to jot down on a small tag, attached to the patient, the salient points of treatment and medication. By the time our train pulled into Jasper at 10:00 p.m., we could safely say that the majority of our patients were "resting comfortably."

While in Jasper our supplies were replenished and we were able to get some plasma which we immediately administered to those most in need. The two Jasper doctors left the train and the doctor who had administered first aid at the site took charge again. Two fresh nurses replaced three of our nurses who had to return to their families. We carried on until we were relieved by fully equipped army personnel from Edmonton who boarded the train at Edson, 100 miles west of Edmonton. Although we had been on duty 20 hours, it was with a deep sense of personal loss that we rendered up "our boys" to other capable hands.

The Jasper Chapter of Registered Nurses went wearily home to collect up families and to resume household tasks but they were proud, indeed, with the knowledge of a big job well done.

This is our story of the Canoe River wreck. The Jasper nurses, a group of housewives, were able to handle it because they had previously organized. The automatic reaction of trained nurses illustrates the fundamentals of the Civil Defence nursing course. Our story brings into focus the capabilities of untrained personnel as shown by the heroic cooperation of young soldiers. The teamwork evidenced by our neighbors, the train crews, and the staff of the diners all contributed to a successful undertaking. The Canoe River wreck shows that every Canadian nurse can serve her profession and her country by assuming her place in the over-all plan of Civil Defence.

Nurses' Contribution

Nurse advisers have a valuable contribution to make in the planning of hospital buildings, teaching units, clinics, etc.; in selecting and testing equipment; and in assessing the number and categories of staff which will be required. They can advise against the expenditure of money on buildings which cannot be used owing to lack of funds to equip them or the lack of personnel to staff them. They can also help to design home-care programs to supplement the service of hospitals and to plan preventive and curative programs with equal emphasis on both promotion and cure.—

WHO Expert Committee on Nursing
Second Report.

Lyle Creelman *Writes . . .*

I wish you could have a glance at the world map in our Nursing Section office. It is dotted with colored pins, now over 100, each representing a WHO nurse in one of the various projects where they are assisting countries to prepare their own nursing and health personnel. The largest grouping is in the countries which we used vaguely to refer to as the "Far East"—India, Afghanistan, Pakistan, Thailand, Ceylon, Malaya, and Borneo. There is another cluster in the "Middle East"—Lebanon, Syria, and Iraq. Central America also has a few and the vast area of South America has a sprinkling.

Fifteen of the present nursing staff are from Canada. The others come from the United Kingdom, United States, Denmark, Holland, France, Switzerland, Belgium, Finland, New Zealand, Chile, Australia, Norway, Portugal, Panama, Brazil, and Colombo.

The real nursing projects usually start with giving assistance to a school of nursing which may already be in existence or one which is being started. For example, Mary Harling (Montreal) who went to Penang in Malaya found a very good school under the direction of the British Colonial Service. However, there was need for further assistance in this school, which WHO was asked to give. Our team helped introduce public health aspects and some clinical supervision. There was need also for the extension of this supervision to hospitals outside Penang to which students were sent for experience before they completed their training. Along with the nursing, midwifery was given attention. Fully qualified midwives were prepared and supervision was given to the *bidans* who are the local untrained midwives. The question of domiciliary midwifery teaching was a problem. The *bidans* used to return to their *kampongs* (villages) without any experience of the home conditions under which they would be working.

One of the greatest difficulties was the educational background of the nursing students. It was estimated that only about 25 per cent had sufficient background ability to attain to professional nurse level. This created a real problem in teaching as, of course, instruction has to be geared to the average level. The solution was to limit the school of nursing students to the 25 per cent who could attain professional status and who would be able to assume leadership positions and to prepare a less qualified group in a shorter period for duties as ward auxiliaries. This program in Penang is continuing and we hope that the team will have a male tutor as an additional member. Male hospital assistants (or dressers) take the same course as the female nurses. However, in Malaya, nursing implies a loss of prestige to the male student and it is hoped that the provision of an international male tutor will help to give the male nurse the status he deserves.

Helena Reimer (Winnipeg) has gone to a completely new situation—to the delightful sounding city of Phnom Penh in Cambodia. When Elizabeth Hill, our nursing adviser, first visited there she was taken in the King's private aeroplane to see the ruins of Angkor Vat, which was one of the greatest architectural feats in the history of the world. It is said that thousands of artisans, artists, and laborers carved and chiselled frantically for over 30 years to achieve this wonder. Willy Visscher is with Helena and soon a Swiss nursing instructor will join them and later on a midwifery teacher. This will complete the team of four who are establishing a new school in which there is plenty of room for experimentation to find the kind of curriculum which should be developed for this country. Helena's first reports have just been received;

she really must tell you herself about her work but I cannot help quoting some of her statements which indicate the soundness of her approach to her task of helping to establish nursing in Cambodia:

> The Cambodia people are shy so it took us some time just to get acquainted. Then we placed ourselves in a learning position and let them talk to us about their country, its people and its customs, its resources and its needs. They are both (the two Cambodian nurses working with the WHO team) well informed and proved to be able teachers. They made us realize how important it is for us to know something about the country if we are to develop a program to really serve the needs of the country.
>
> In introducing these two young people to modern nursing we have become very critical of our own concepts because there is so much, that we have taken as so right and for granted, that does not fit in with the needs of this country at all. We are also fully convinced that the only sound way of introducing a new program into a country is by working step by step with some responsible persons even if it takes much longer. Let it take root in their thinking as they help to develop it, so that it will be something that they themselves have planted and watered.
>
> We have said that the work required vision and common sense but it also required a persevering interest. In this climate, where enthusiasm and interest drop so easily, a steady unshakeable day-to-day enthusiasm seems to be an essential personal qualification for the work.

North to Taipeh in Taiwan (Formosa) we come to the University Hospital School of Nursing which is directed by Stella Chen, a well known Chinese nurse who has studied in Toronto. She needed assistance and WHO is sending in a group of five. The first to go was Isobel McKay (Toronto). Isobel is really returning home because her parents are there and have been leading missionaries in Formosa for many years. Closely associated with this school of nursing, WHO is also going to give assistance in developing a field training program for nurses and other personnel.

There are many other countries where nursing assistance is needed—for example, Ethiopia. When Miss Magnusen, nursing adviser, visited that country, she found that the problems are very great and qualified personnel very few indeed. As a matter of fact no qualified Ethiopian doctor exists as yet and only one qualified Ethiopian nurse is working in the country.

You may recall that nursing in Ethiopia had a severe setback several years ago when the daughter of the Emperor Haile Selassie, who had taken her training in London, died. By taking nursing herself she indicated to other girls that it was a worthwhile career. One of the great difficulties, of course, in Ethiopia is the fact that only a small number of girls are educated even up to the secondary school level. However, education is now being given top priority and we hope that this will be reflected in the general level of education for girls. At the present time the total number of girls in secondary schools in the whole country is less than 100; the population is estimated at some 12,000,000. The first nurse to go to Ethiopia will be Queenie Donaldson (Vancouver) who will be the nurse member of a VD demonstration team located at Addis Ababa.

Turkey will be the first country in Europe to receive a team of WHO nurses. Marion Pennington (Cranbrook, B.C.) will be there to help develop some post-graduate courses.

As an example of another type of activity, Marjorie Hudson (Montreal) will soon be completing her assignment in a TB demonstration project in Delhi. I wish you could have visited with her, as I did, in Old Delhi to see real problems in TB control—great poverty, crowded living, and ignorance, together with relatively complete lack of facilities for care. In the picture you see Marjorie with Miss Thomas, the Indian nurse who is

Home visiting in New Delhi. Home treatment for tuberculosis is essential in countries like India where sanatorium accommodation can never hope to be adequate. The young doctor examining the patient is a WHO Fellow from Ceylon. MARJORIE HUDSON explains to the family the needs and care of the patient.

working with her and who will take over responsibily for the nursing activities of the demonstration. Miss Thomas was married recently and Marjorie felt very honored in being asked to be her bridesmaid.

Justine Delmotte (Montreal) is working hard in a Yaws demonstration project in Thailand. Some of our senior officers who visited there recently were much impressed with the work that she is carrying on under very difficult conditions. Her duties take her on trips through the rural areas and sometimes she has no bed to sleep on and only a straw roof over her head. She rolls up her sleeves and goes about her job of teaching local personnel with real spirit. Here you see Justine with her following of most attractive Thai youngsters. Probably some of them have been treated for yaws.

Our first Health Demonstration Area is in El Salvador. Jean Webster (Vancouver) joined that team some time ago. She has been assisting in training auxiliary personnel as the first step in developing the public health nursing service in that area. There are few nurses in El Salvador. The first task, therefore, was to train some type of personnel who could work under the supervision of the few available nurses.

These are just samples of some of the activities in which Canadian nurses with WHO are engaged.

At Headquarters we continue to be very busy trying, among other things, to find more nurses for new projects in many countries. Personally I am looking forward with great anticipation to a visit to Finland, where I shall participate in a seminar on in-service education and in social casework which is being organized by the European Office of the United Nations. It will be a real learning experience for me and I hope that I may also have time to see something of the excellent nursing program there.

In Thailand, one person in 18 suffers from yaws. In order to tackle this problem on a mass basis, the Thai government called on the United Nations for aid. A joint team composed of UNICEF and WHO experts was immediately rushed to Thailand where they helped train local personnel, provided the necessary medical supplies and transport. Soon the campaign was well under way in the province of Ratchburi. Here JUSTINE DELMOTTE holds an open-air clinic in Ratchburi.

Dermatitis caused by wearing apparel begins at the site of contact with the offending material, five days or more after the garment was first worn. This is the length of the period of incubation for the development of sensitivity. The dermatitis may appear before five days if the patient has been sensitized to the offending chemical in the garment by exposure from some other source previous to the time that the garment was first worn.

Nursing Profiles

Myrtle Pearl Stiver, known affectionately to her wide circle of personal acquaintances as "Penny," will start this month to make her imprint on the affairs of the Canadian Nurses' Association when she assumes the duties of general secretary-treasurer of our national organization.

Born in Grey County, Ontario, of Holland Dutch and English parentage, Miss Stiver received her elementary and secondary school education in Stayner. She entered the school of nursing of the Toronto Western Hospital. Following graduation in 1932, she took post-graduate training in psychiatry and mental hygiene at Toronto Psychiatric Hospital. Private nursing occupied her professional activity for the next seven years. She was awarded the Beatrice L. Ellis Scholarship, given by the T.W.H. Alumnae Association, for a year's study in public health nursing at the University of Toronto School of Nursing. She secured her Bachelor of Science degree in 1947 from Teachers College, Columbia University.

A brief period of staff work with the Victorian Order of Nurses preceded Miss Stiver's plunge into official agency activity. After two years on the staff of the Toronto Department of Public Health, she joined the Division of Venereal Disease Control of the provincial Department of Health as nurse epidemiologist. During the next six years she served with that division as supervisor, nurse consultant and, finally, regional supervisor and consultant in venereal disease. In 1949 she was appointed director of public health nursing with the city of Ottawa Department of Health.

That is Pearl Stiver, the nurse—the new general secretary. Thoughtful, capable, cooperative, energetic, with a real flair for organization and administration, Miss Stiver will play a vital role in nursing in the ensuing years.

It is not enough that the nurses of Canada should know only these outlined facts regarding their appointed leader. What of Penny Stiver, the woman? One of her outstanding characteristics is her even disposition. She is usually happy, looking on the bright side of things as far as possible. A well adjusted personality, she gets along evenly with people. She is a good listener, easy to talk to, for those who come to her with their problems. She believes in helping people to work out their own solutions rather than laying down a line that should be followed. Nevertheless she can and does take a firm stand in expressing her own opinions.

Miss Stiver's interests outside her working day are many and varied. An amateur photographer for many years, she has excellent pictorial records of the places she has visited. Recently she acquired a moving picture camera and is currently studying the art of producing good movies.

A "home-body" in the truest sense, Miss Stiver is firmly convinced that cupboard shelves should be well stocked. Each year she revels in preserving, making jam and pickles, with the ardor of a mother of ten. All the goodies rapidly disappear for she seldoms visits a person, sick or well, without leaving a sample of her homemade wares. She can seldom pass a counter of gift wrappings without buying the attractive paper, cards and ribbons to do up the many thoughtful presents that are always on hand for that "special occasion." Her circle of friends is large because she is herself a friend.

Her flowers, a garden and all outdoors are probably her most absorbing interest. Proof of her "green fingers" is seen in her large collection of African violets in magnificent bloom. Before she owned a car she spent many happy years as a youth hosteler, cycling far and wide. On a vacation trip to the Rockies she had a wonderful time on a hiking tour. She prefers to desert the main highways and take the more leisurely paths in order to better see the plant and bird life.

A member of the University Women's Club, Miss Stiver will live at their residence in Montreal.

Winonah Lindsay has been appointed secretary-registrar of the Association of Nurses of the Province of Quebec, succeed-

ing **Margaret M. Street** who has joined the faculty of the School of Nursing, University of British Columbia, Vancouver.

Born in Montreal, Miss Lindsay is a graduate from the Queen Elizabeth Hospital in that city and holds her Bachelor of Nursing degree from the McGill School for Graduate Nurses where she specialized in teaching and supervision. A broad variety of hospital experience has given Miss Lindsay a keen insight into the present-day problems of schools of nursing. In addition, she served overseas with the R.C.A.M.C. during World War II and for a time afterwards was educational assistant in a large D.V.A. Hospital. An active member of the British Empire Service League, Miss Lindsay is an omnivorous reader. Bilingual, she will guide the destinies of this, the largest provincial nurses' association in Canada, with unerring aim toward the goal of greater service.

Van Dyck, Montreal

WINONAH LINDSAY

During the past eight years when, as general secretary of the C.N.A. **Gertrude M. Hall** has consulted with hundreds of hospital administrators and directors of nursing regarding their problems, a decision was building up in her mind that she must some day direct a school of nursing herself and try to put into effect some of the cherished plans she has had for others. It was no surprise to her colleagues, therefore, when she accepted the invitation from the Board of Directors of the Calgary General Hospital to take over the principalship of the school of nursing there. She began her new duties this month. She will be working in close cooperation with **Dr. L. O. Bradley,** formerly executive secretary of the Canadian Hospital Council, who is now the executive director of the C.G.H. Another well-known nurse who has joined the faculty there is **R. Catherine Aikin,** who is educational director. Miss Aikin, formerly assistant secretary-registrar with the A.N.P.Q., recently completed a year of post-graduate study at the University of Chicago.

We shall all watch the developments in this school of nursing, under the skilled guidance of such distinguished leaders, with keenest interest.

GERTRUDE M. HALL

Jean Graham Church has been assistant director of the School of Nursing at Dalhousie University, Halifax. She succeeds **Marion Pennington** who has gone to Ankara, Turkey, as the representative of the World Health Organization, to assist the Turkish Government in modernizing their health facilities and activities.

Born in New Glasgow, N.S., Miss Church secured her Bachelor of Science degree from Dalhousie University before she entered her nurse's training at the Royal Victoria Hospital, Montreal. After a brief period in general staff work at R.V.H., she enrolled in the course in teaching and supervision at the McGill School for Graduate Nurses. Miss Church joined the teaching staff of the Children's Hospital, Halifax, as science instructor, going on to be educational director. Later she organized an under-

JEAN G. CHURCH

graduate and post-graduate program at the Nova Scotia Sanatorium in Kentville, N.S. Until her present appointment she has been a clinical instructor at Victoria General Hospital, Halifax.

Active in nursing association affairs, Miss Church is interested also in musical organizations. She is a member of the Nova Scotia Opera Association. For relaxation she dabbles in oil painting, plays a smart game of bridge, or tries to outguess the authors of "whodunits."

Phyllis Lavinia Wylie has been appointed director of nursing of her alma mater—the St. John's General Hospital, Newfoundland. Born and educated in St. John's, Miss Wylie holds her diploma in nursing education and administration from the University of Toronto. Following graduation she qualified as laboratory supervisor at S.J.G.H. She served for a couple of years as assistant supervisor of the pediatric floor at the Jewish General Hospital, Montreal, then returned to St. John's as nursing arts instructor. Until recently Miss Wylie was field consultant with the provincial public health nursing service.

An executive member of the Graduate Nurses' Association of Newfoundland, Miss Wylie is a past president of the St. John's General Hospital Alumnae Association and an active member of the alumnae association of the University of Toronto School of Nursing. She is a group captain of the Community Concerts Association and enjoys bowling, swimming and skating.

PHYLLIS L. WYLIE

In Memoriam

Edith M. Brown, a graduate of the Hospital for Sick Children, Toronto, died on July 31, 1952, from a coronary thrombosis. Miss Brown had engaged in private nursing for many years prior to her retirement some time ago.

Lauretta (Hughes) Kneil, a native of P.E.I. who graduated from a school of nursing in Newton, Mass., late in the 19th century and who organized the school of nursing at the Ottawa General Hospital in 1899, died in Ottawa on July 1, 1952, at

the age of 83. One of Mrs. Kneil's treasured mementoes was a medal awarded to her by the American government for her service as a nursing sister during the Spanish-American War.

* * *

Sister M. Mona, a member of the Community of the Sisters of Charity of the Immaculate Conception, who graduated from St. Joseph's Hospital, Saint John, N.B., in 1918, died there on May 31, 1952. Sister M. Mona had held many positions of responsibility in the hospitals of this Community. For a time she was superintendent of the Holy Family Hospital in Prince Albert, Sask. Latterly, she had charge of the outdoor department at St. Joseph's Hospital in Saint John.

* * *

Hilda Keith Smith, who graduated from the Vancouver General Hospital in 1921, died suddenly on August 8, 1952, at the age of 71. Miss Smith was appointed supervisor of the private pavilion at V.G.H. when it was first opened and continued to serve there until her retirement in 1946.

* * *

Augusta (Plett) Stewart, who graduated from St. Luke's General Hospital, Ottawa, in 1917, died suddenly in Ottawa on August 12, 1952, in her 69th year. Mrs. Stewart had maintained her interest in the professional aspects of nursing all through the years.

* * *

Margaret Isabel Thirsk, a graduate of the hospital in Cobourg, Ont., died in Toronto on July 2, 1952, at the age of 72. Miss Thirsk was decorated for bravery while serving with the C.A.M.C. during World War I. She retired from nursing in 1925.

In The Good Old Days

(The Canadian Nurse—OCTOBER 1912)

"At the convention of the Superintendents of Training Schools for Nurses, held in May, 1911, it was decided to form a Dominion Registration Committee. . . At conferences the convener held with representatives of the Graduate Nurses' Associations all across Canada it was most gratifying to find the great interest that was being taken in this question . . . To have a uniform Bill, ensuring uniformity of standards for admission and for graduation throughout Canada, would do away with much trouble and confusion in the future."

* * *

"We hope that eventually all our large schools will have open-air classes equipped on the roofs which may be carried on all the year round. When a child of below normal health is found in the classroom he could be sent to the open-air class where food, rest, and fresh air would bring him to his normal health so that he might again take his place in his grade."

* * *

"*Aspiration*—our motto for the next triennial period—expressed a desire to seek eagerly after that which is above us. That was the inspiration of the International Council of Nurses and that is its goal. The essential essence of nursing is not merely to offer skilled help to suffering and diseased humanity—it is something far higher than that. It is the endeavour to appropriate the spiritual force which is the common heritage of our profession, bequeathed to it by many noble men and women who have served the sick of all ages in every land; a reserve force upon which as long as we walk worthily we may freely draw; a force potent with grace so that in helping to heal the body, those to whom we minister may discern the fineness of motive which inspires our vocation, the uplifting spiritual zeal which inspires our service, and may be sustained and comforted thereby." — MRS. BEDFORD FENWICK, at the *1912 I.C.N. Congress.*

* * *

"It has been revealed that the use of the ice bag is positively harmful in appendicitis. In 50 per cent of the operations, there appeared to be a noticeable lack of effort on the part of Nature to wall off the appendix from the rest of the abdominal cavity when the ice bag was used."

Institutional Nursing

Testing Nursing Aptitude

MARJORIE FAHRIG, M.A.

Reports of the Canadian Nurses' Association regarding the size of the annual graduation class indicate that 14-40 per cent of the nursing failures occur in the preclinical training period and are largely due to academic failure. Such failure represents a large cost to both the hospital and the student. In terms of the first, there is the actual money cost of supporting the student during an unproductive part of training. The presence of a failing student tends to lower the "average" of the total group for which courses must be planned. Much costly time and attention are given by instructors who might otherwise be involved in guiding the more capable students. In terms of the second, the experience of failing and being forced to withdraw may have a traumatic effect upon the student. All of these costs might be avoided if the selection process were adequate in discriminating between those most and least likely to succeed in nursing training.

The object of this study is to evaluate the merits of an aptitude test for nurses. The thesis is that an aptitude test will select those individuals who will succeed in the classroom work of the preclinical period. It is not expected that such a test will throw light upon other factors such as temperament, emotional stability, etc., which are undoubtedly important in later training. The greatest failure rate is sustained in the preclinical period, when classroom work receives the greatest emphasis.

The Aptitude Test (Form 2) of the George Washington University Series of Nursing Tests was administered to 200 students distributed in five Canadian (Grade A) teaching hospitals, at the end of their preclinical training. This test is composed of six parts purporting to measure:

1. Judgment in nursing situations.
2. Visual memory.
3. Memory for content.
4. Information on general subjects related to nursing.
5. Scientific vocabulary.
6. Ability to understand and follow instructions in writing a nurse's report.

The tests were administered under the direction of the superintendent of nurses in each of the hospitals and were returned to the writer for scoring and evaluation, accompanied by information concerning grades obtained in the preclinical period.

The means and standard deviations of aptitude test raw scores and of class and ward averages were calculated. These results are shown in Table I.

TABLE I
MEANS AND STANDARD DEVIATIONS OF MEASURES USED IN HOSPITAL 1-5

H	Measure	Mean	S.D.
1.	A.R.S.(a)	159.7	22.06
	C.W.A.(b)	83.5	4.56
2.	A.R.S.	157.2	17.29
	C.W.A.	80.0	
3.	A.R.S.	179.5	10.65
	C.W.A.	76.9	4.32
4.	A.R.S.	178.7	7.46
	C.W.A.	79.8	5.12
5.	A.R.S.	182.1	7.00
	C.W.A.	79.8	12.90

(a) Aptitude test raw scores.
(b) Classwork averages.

It is apparent from this table that marked differences exist between the groups. The discrepancy between aptitude scores and classwork averages when, for example, hospitals 1 and 5

are compared suggests that the grading policies of the hospitals are at variance. This fact takes on definite significance when a test is considered for use in different areas without special standardization.

The next statistical procedure carried out was a series of correlations between aptitude test raw scores and classwork averages, aptitude raw scores and practical marks, intelligence test percentiles and classwork, intelligence percentiles and practical work (see Table II).

TABLE II
CORRELATION OF VARIOUS MEASURES IN HOSPITALS 1-5

H	*Measures Correlated*	r
1-4	A.R.S. and C.W.A.	.32 to .47
1-4	A.R.S. and P.W.M.(c)	−.75 to +.41
1,3,4	I.P.(d) and C.W.A.	.19 to .38
1,3,4	I.P. and P.W.M.	.06 to .17

(c) P.W.M.—practical work mark.
(d) I.P.—intelligence test percentiles.

The correlations between aptitude tests scores and classwork averages varied from .32 to .47 in four hospitals. In contrast to this, the aptitude raw scores and practical marks varied from minus .75 to plus .41. The range in the latter suggests that the test is not adequate for predicting success in the practical side of nursing. The correlations between intelligence tests results and classwork averages are lower and show greater variability than the aptitude correlations, suggesting that the aptitude test is a better measure of success than the intelligence test. The correlation .13 found between aptitude raw scores and classwork averages, when the total number (200) were considered together, is accountable in terms of the variation in mean scores of the measures, and in terms of the fact that in hospital 5 the practical mark was combined in the final average.

From the foregoing results, the following statements may be made:

1. A positive relationship exists between the aptitude test and success in the academic training in the preclinical period.
2. This relationship is greater than that demonstrated between intelligence test results and success.
3. The test must be considered in terms of the individual hospital and results obtained with one group cannot be applied without modification to another.

In conclusion, the writer would like to suggest that this test has value as a selection tool but with the following reservations:

1. The results from one hospital will not necessarily apply to another. Each hospital should give the test to a series of classes in order to establish local norms.
2. The extent to which such a test is valid is dependent on the size of the population from which a group is to be selected.
3. The test will not predict success in the practical side of nursing.

ACKNOWLEDGMENTS

I wish to express sincerest appreciation for the assistance received from the directors of nursing of the Vancouver General Hospital, Winnipeg General Hospital, Royal Alexandra Hospital, Edmonton, Victoria General Hospital, Halifax, and Victoria Hospital, London Without their cooperation, this study would not have been possible.

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Evaluating Faculty Competence

SISTER ST. THOMAS D'AQUIN, O.S.A., M.SC.

Since self-evaluation is essentially a problem of the teacher, it would seem wise to give an opportunity to the faculty members to evaluate themselves and their work by using some sort of rating scale. Every progressive teacher is eager to help ascertain the qualities that make for better teaching and for the highest development of her students and seeks to attain outstanding qualities.

The students may likewise evaluate the teachers. There are various types of student ratings of teachers—for example, check lists prepared by the director herself or by the faculty members to which the students may answer "yes—no" or "true—false." The items, about 75 or more, might enlarge on the following points: personality, attitude towards work, students, preparation of the class, and teaching tech-

Sister St. Thomas d'Aquin was formerly instructor at the School for Graduate Nurses, Laval University, Quebec, and is now at Hôtel-Dieu, Quebec City.

niques. Sometimes the students can add additional comments. A pattern of such a rating scale is as follows:

Suggested Questionnaire on Evalution of Course

PART I

Answer questions "Yes" or "No"

1. Did the content of the course start at the level for which you were prepared? .....
2. Have you found the subject matter interesting? .....
3. Do you consider the subject matter of this course a valuable addition to your knowledge? Commensurate with the effort expended? .....
4. Has the course helped you to make other educational experiences more meaningful? .....
5. Has the course helped you to develop a more wholesome or Christian philosophy of life? .....
6. Has the course opened up for you any new field of interest? .....
7. Has the course increased your understanding of human nature? .....
8. Were discussion periods long enough? .....
9. Were discussion periods valuable? .....
10. Have your powers of observation been increased because of this course? .....
11. Was the presentation of material interesting? .....
12. Were the methods of presentation varied? .....
13. Were the methods used effectively? .....

PART II

1. Approximately how many hours a week have you spent in studying for the course? .....
2. Do you feel this was sufficient study to master the material? .....
3. If not, explain what factors prevented you from further study.

.....

.....

.....

4. List the subject touched upon in class which you would like to pursue further.

.....

.....

.....

5. Do you feel you have gained knowledge through the use of the test in this course? .....
6. What suggestions would you make for improving this course?

.....

.....

.....

The essay type of rating may also be used. Some classroom instructors, in the final test at the end of the course, ask a question about the appreciation of the course and the teacher. If two student judges attribute the same trait to the same person in the same degree, an instrument of measurement is manifested which has some quality of reliability. Generally speaking, student ratings are regarded as valid since it is students that are being taught and who alone are competent judges of the daily conduct of teachers. Moreover, they usually give every indication of sincerity in rating teachers.

The director of the school can also make some evaluations, either individually or by groups. An evaluation of the methods of teaching can be made, for instance, through a judgment of the use of visual aids by the teacher or of new and active methods of teaching —if interest is shown in some study or research concerning nursing education; if teachers are active members of the nursing organizations; if they participate in school activities and cooperate at faculty meetings, and if they take their responsibilities concerning faculty policies seriously.

This evaluation can be done individually but the nursing school faculty should evaluate its own competence not only as individuals but as a group. In an article in *Hospital Progress,* Sister M. Olivia Gowan suggests some criteria for such evalution as follows:

1. Are the graduates of the school sought by other schools? hospitals? agencies?
2. Are the ratings of graduates good in the general practice of nursing?
3. Do the schools offering affiliations seek students from the school year after year?
4. Do the graduates do well in advanced positions?

5. How many graduates enter universities for advanced education?

6. Do they have good academic and professional rating?

7. Do graduates encourage young women to enter the school?

8. What contributions have the graduates made to the profession?

9. Are the records of students in Registered Nurse examinations good?

In each school other indications of faculty competence can be found which each group may add to evaluate its own work.

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STEP UP AND BE COUNTED!

This challenge is ringing out to *all graduate, licensed practical and psychiatric nurses* in Manitoba. Civil Defence planning requires accurate information regarding the total nursing strength in that province. To secure this information a careful count of all nurses, with certain details to be filled in on the forms provided, will be made during the last week of October, 1952.

Step up and be counted! Registration centres will be located during that week — **October 27-31** — *in all hospitals in Manitoba.* The Manitoba Association of Registered Nurses is enthusiastically supporting this census-taking project. Be as active yourself.

How can every nurse help?

1. By registering early in the week.

2. By rounding up everyone who is or ever has been a graduate nurse, a licensed practical nurse, or a psychiatric nurse and seeing that they "step up and be counted."

3. By volunteering for at least part-time service as a census interviewer.

Manitoba is serving as the guinea pig in this essential experiment. Success in obtaining satisfactory results there, will influence similar surveys in the other provinces.

The Date — October 27-31, 1952.

The Place — Every hospital in Manitoba.

The word *efficiency* applied to a nurse so often conjures up a picture of a brisk, bustling person crackling with starch who whips out stitches and applies poultices with great dispatch but no sympathy; one to whom a human being in a bed is a disease which happens to have a personality rather than the other way about. When applied to work in a hospital this manual dexterity is not sufficient. There must also be a strong sense of what is, and will be, needed by the patient, both mentally and physically. There must be dexterity, neatness, and punctuality in practical matters as well as thought to forestall the inward growth of fear and unhappiness. To this end great experience of human needs and failings is necessary, together with a large capacity for charity in the sense of St. Paul's letter, and the cultivation of emotional detachment or at least of good emotional control. All these qualities go to the blending of an efficient nurse so that she will be learning to be more efficient during the whole span of her working life.

—*The Nursing Times.*

Public Health Nursing

Health Education Program for Student Nurses

MARGARET MACKENZIE

The aim of the course in health education at the Toronto Western Hospital is to help the student develop a positive attitude towards mental and physical health for herself and her patients and gain an appreciation of the social aspects and implications of illness for the patient, the family, and the community, so that she may function as a health teacher. The course has been developed around four basic points:

1. It is treated as a continuous course throughout the first two years, with additional community experience in the third year.
2. The individual and the community are considered concurrently.
3. There is community observation in connection with each series of lectures.
4. The material presented is basic and supplements that which is given in other courses. It has been developed in close cooperation with the instructors in the various clinical services and every attempt is made to illustrate that the social aspects are a part of total patient care.

The course is presented in four parts to correlate with the basic curriculum —three in the first year and one in the second, for a total of approximately 75 hours.

PART I

This deals with the physical health of the individual and the provisions made by the community for its preservation. The following premises form the basis for this unit:

1. That in any health program active participation by the individual and planning by the community are essential.
2. That knowledge and understanding precede participation.
3. That the student health service program can provide good teaching opportunities.

Our program provides for preentrance health examinations conducted at the school by school physicians. On entrance a brief review of the examination shows the individual the value of participating in and maintaining good health. At this time the function of the student health service is outlined and stress is laid on the fact that it can only fulfil its function if the student makes her needs known. Thus she is encouraged to come with any problems or complaints and a course of action is discussed with her. A sympathetic ear and a positive attitude on the part of the nurse in charge is necessary if this is to be a constructive program. It is essentially a counselling service.

Two examples will serve to illustrate the methods employed. Tuberculin tests are compulsory, by provincial law, for all students entering a school of nursing. Previous to testing, an explanation in simple, non-technical language tells the purpose, dosage, method, interpretation and significance to the individual. The students read their own tests, are responsible for returning for repeat tests. There is, of course, an adequate checking and recording system but every effort is made

Miss Mackenzie has been responsible for the organization and development of this program. She is health instructor at Toronto Western Hospital.

to encourage the students to accept responsibility.

The second example concerns nutrition. When the course in normal nutrition is being given, our discussion centres around the factors that interfere with good nutrition, the socio-economic factors, reasons for poor eating habits, and how these problems may be approached. The community approach is made by a discussion on safe milk supplies, a film on commercial pasteurization, government control, home pasteurization and care of milk, etc.

PART II

Following the lectures on individual and community health, Part II starts with a brief introduction to teaching. Examples from Part I are used to illustrate method. The points stressed are:

(a) Discovering the patient's needs; (b) presentation of material from the point of view of interest, the patient's level of understanding and approach; (c) opportunities for teaching; and (d) the need for the nurse to understand the patient's difficulties and why each patient requires individual consideration.

This leads to the development of the individual. Both heredity and environment are discussed. Heredity is not considered in detail, the emphasis being placed on the fact that each individual has started life with a distinct set of characteristics that are peculiar to him alone. From here we go on to those aspects that affect the development of the individual; some of the ways in which our culture provides us with patterns for living; some of the variations that occur in different cultures; and the influence of the group on the individual. The changes that have taken place in our culture and the effect these changes have had are also brought out. Thus an attempt is made to show the development of the various social needs in the world of today.

The fact that there is recognition of individual needs and the community's attempts to meet them is provided through tours of social agencies, such as community or settlement houses. The problems of environment are shown by means of a visit to Regent's Park Housing Project and the needs of special groups by a visit to the Canadian National Institute for the Blind.

The need of dealing with the patient on an individual basis is provided by a day spent in the Out-Patient Department. The student observes several interviews with new patients. She then accompanies one through the clinic, explains the routine admission procedures and remains with the patient during the doctor's examination and the interview with the Hospital Health Service nurse (a public health nurse of the City of Toronto Health Department who acts as liaison between the hospital and the district). She remains with the patient if he is to be admitted or until he has his instructions and appointment for a return visit. Emphasis is laid on how the interviews are conducted, what information is received, and how assessment of the patient's eligibility for clinics is determined, also the sources of referral. This provides the basis for a discussion with the students and demonstrates the contribution the department is making to the health care of the people. The student then observes a home visit which assists her in recognizing some of the problems of our patients.

PART III

In the medical and surgical blocks that follow in our curriculum, Part III attempts to deal with some of the social aspects of illness as they affect the patient and his family and the significance to the community.

The need for recognizing problems and their referral, the application of her knowledge to prepare the patient for his return home, the presence of various community services and how they are provided through official and voluntary agencies are all discussed. This approach is general rather than specific. The application to specific problems is dealt with by the clinical instructors in medicine and surgery.

PART IV

The fourth and last part of the

course is given during the student's experience in the Out-Patient Department. The four-hour class period for each week is an uninterrupted morning session. There is ample opportunity for student participation and, as the group is small, it may be informal.

The student is assigned to one main clinic for the entire four-week period so she does not learn a variety of routines. She has an opportunity to know the patients, their ability to carry out teaching which has been given, and to assess her own teaching. The student does assist in various other clinics such as the chest clinic, venereal disease, prenatal, etc., so that her experience is not limited. These are held in the afternoon or evening and do not interfere with morning assignments.

Again observation is provided in the interviewing of new patients coming into the clinic. The student is encouraged to take the initiative in looking for and referring problems. The administration of the department and the nursing staff work in close cooperation to make the students' experience an educational one.

Field work is provided for some of the students by the Victorian Order of Nurses at certain periods of the year. This is a valuable experience as they have an opportunity to see and participate in bedside nursing programs as well as a teaching program. The other students are taken on home visits early in their experience and again later. These visits are made possible by referral from the Hospital Health Service. The students prepare for the visits by obtaining information from the histories and social index cards of the patients. On return from the visit they report to the Hospital Health Service the problems, teaching given, and other pertinent information.

In the classes at this time the student presents a social study on a patient she has visited. This includes a budget for the family and thus she realizes the many financial needs that must be met and appreciates the services provided by the social and health agencies. Each student also prepares for a demonstration of a home nursing situation, using one of the families visited as a setting. She includes a picture of the total situation and how, as a nurse, she might proceed to deal with it and teach the patient or the family. Suggestions and ideas for alternative methods are discussed by the other students during the demonstration. Here the student has an opportunity to apply her knowledge in relation to specific conditions —for example, how she might help a patient to obtain the extra rest that she had been ordered or how a special diet may be fitted into the family pattern of eating, which might also be improved.

Throughout the course no particular emphasis is given to public health nursing as a special post-graduate field. The emphasis rather stresses the fact that the nurse, as a professional worker, should be prepared to consider the patient as an individual, with difficulties that have to be met in a way that is satisfactory to him and most compatible with his environment. Also as a professional person in the community she should know the available resources and be prepared to encourage and develop them.

A feature of modern nursing education is the emphasis given to the planning of curricula based on the educational principles common to all disciplines. The nurse has to be taught to react to situations which are changeable in themselves (because human beings are dynamic) and which are also affected by advances in medical and general science and by the impact of one culture upon another. The help of educationists, as well as of persons familiar with the culture, and particularly educated members of the society who have learned to look objectively at their own customs and beliefs, is urgently needed in developing a program for the school of nursing.

WHO EXPERT COMMITTEE ON NURSING *Second Report.*

Aux Infirmières Canadiennes-Françaises

Bonne Entente

L'Abbé Arthur Maheux

Le problème de l'unité nationale se peut envisager de différentes façons. Depuis plusieurs années, à travers tout le Canada, j'ai essayé de l'expliquer par des conférences, des brochures, des articles de revues et surtout par des livres. Je ne prétends pas avoir résolu toutes les difficultés. Mes articles hebdomadaires du *Star de Montréal*—360 en sept ans—offrent une grande variété de détails sur ce sujet. Sans doute, il est préférable d'aller tout droit aux racines du mal; or ce sont bien les préjugés qui sont à la racine de nos problèmes nationaux.

Toutefois, mettons-nous à un autre point de vue et étudions les relations entre l'unité nationale et cette Université Laval dont on célèbre le Centenaire. Et d'abord posons nous cette question: Comment l'idée d'une université s'est-elle dévelopée chez les Canadiens francais? On dit souvent que les Canadiens français ont beaucoup tardé à établir une université et que, par l'absence d'une telle institution, ils ont été plutôt ignorants, et conséquemment méprisables. Est-ce vrai?

Vous tenez votre congrès à Québec à l'occasion d'un Centenaire—ce que l'on appelle le Centenaire de l'Université Laval. C'est une étiquette trompeuse, qui demande explication. Il y a vraiment un centenaire, mains c'est celui de la Charte universitaire obtenue par le Séminaire de Québec en 1852. Ce n'est pas le centenaire de l'enseignement au degré universitaire en Nouvelle-France ou chez les Canadiens français.

En fait, pour trouver le commencement d'un tel enseignement il faut remonter jusqu'à 1635. Cette année-là, quelques mois avant le décès de Samuel de Champlain, les Jésuites ouvrirent un collège sur les hauteurs du Cap Diamant, non loin de l'habitation du gouverneur et en face de la Basilique d'aujourd'hui. C'etait un "collège classique," c'est à dire une combinaison de cours primaire supérieur (high school) pour les quatre premières années et d'un collège des arts et sciences, pour les dernières quatre années. Ce cours de huit années était précédé de classes élémentaires pour ceux qui n'étaient pas assez préparés à l'étude du latin. Après ces huit années il y aurait bientôt des cours supérieurs de sciences pratiques, telles que la navigation, l'arpentage, les mathématiques.

Ce collège des Jésuites avait la même organisation que les collèges des Jésuites en France et autres pays d'Europe. Ces collèges jouissaient déjà de célébrité en Europe par l'excellence de leur enseignement. Ce fut certes un coup d'audace de mettre sur pied à Québec une telle institution, à un moment où la population totale du village et des environs de Québec ne dépassait guère les trois cents âmes, avec par conséquent peu d'enfants pour suivre les classes.

Cette audace avait sa cause dans l'exemple de l'Espagne en Amérique du Sud où l'on ouvrit collèges et universités peu après l'établissement des Blancs. France et Espagne avaient la même ambition: instruire et former les Indigènes aussi bien que les Blancs. Les sauvages n'y réussirent guère et il fallut abandonner ce bel espoir mais l'entreprise tourna à l'avantage des Blancs.

Les Jésuites furent seuls à Québec jusqu'à l'arrivée du premier évêque—Monseigneur François de Montmorency-Laval. C'est en 1659 qu'il arriva à Quebec. Son premier soin fut d'organiser un séminaire pour former les jeunes gens à la prêtrise et à cette fin il obtint des lettres patentes (une

charte royale) du Roi de France en 1663. Ce fut le début—assez précoce—de l'enseignement de la théologie, au même niveau que dans les écoles de théologie d'Europe. Dès ce moment la Nouvelle-France avait l'équivalent de deux facultés: les arts chez les Jésuites et la théologie au séminaire.

Ce n'était pas assez pour l'ambition de Mgr. de Laval. Il résolut d'avoir aussi un Petit Séminaire en 1668. Ce devait être un collège classique. Cependant, la faiblesse numérique de la population ne pouvait assurer l'existence de deux collèges, surtout au même endroit. Aussi l'évêque fit-il un accord avec les Jésuites. Il enverrait à leur collège les enfants de son séminaire pour les études classiques et il leur donnerait le reste de la formation au séminaire même. Cette combinaison se continua toute la durée du régime français, jusqu'à ce que la Guerre de Sept Ans forçat les deux institutions à fermer leurs portes, vu que Wolfe, installé sur les hauteurs de Lévis, lançait ses obus sur toute la ville.

En tous cas il est légitime de dire que l'enseignement au degré universitaire fut en Nouvelle-France une institution permanente depuis 1635 pour les arts et depuis 1663 pour la théologie. Le Collège des Jésuites a célébré son troisiéme centenaire en 1935 et le séminaire le célébrera en 1963.

Vous demanderez ce qu'on faisait pour le droit et la médecine. Je répondrai: très peu. On avait peu d'estime pour les hommes de loi en Nouvelle-France. Les seigneurs administraient la justice, chaque seigneurie ayant sa propre cour, et le Conseil Souverain, où siégeaient le gouverneur, l'intendant, l'évêque et quelques autres, entendaient aussi les causes. Un nommé Verrier donna des cours publics de droit. Quant à la médecine il n'y avait que l'apprentissage.

Certes, il eût été facile de donner des cours de droit et de médecine. Même en France certaines facultés, en ces matières, avaient peu de professeurs et peu d'étudiants. Mais le gouvernement de Paris se montra peu généreux pour la colonie en ce domaine. Il eût suffi de peu d'argent pour faire vivre en Canada l'enseignement supérieur mais en cela ce fut comme pour l'imprimerie qui fut refusée aux colons français, tandis que les colons anglais l'eurent dès 1639.

Le Collège des Jésuites et le Séminaire de Québec enseignaient sans avoir licence de conférer des diplômes; mais cela ne diminue en rien la valeur de l'enseignement qui était vraiment au degré universitaire d'alors pour les arts et pour la théologie; il n'avait rien d'inférieur comparé à la France et aux autres pays d'Europe, y compris l'Angleterre; il était aussi bon que l'enseignement dispensé dans les colonies anglaises. Harvard commença en 1636 comme simple collège classique, pour devenir plus tard une université complète. A Québec les deux maisons en viendraient à être fusionnées, pour devenir, aussi, une université complète. Quand cette combinaison se produisit-elle? Elle fut le résultat de la Guerre de Sept Ans et du Traité de Paris (1763) et l'effet de la politigue adoptée par la Grande-Bretagne, nouvelle maitresse, à l'égard des Canadiens français.

Le nouveau gouvernement était protestant et agirait naturellement dans le sens protestant. L'une de ses premières décisions fut de supprimer les ordres religieux, particulièrement les Jésuites et les récollets. On ne les tua pas, on ne les exila pas, mais on leur interdit d'accepter des novices et d'enseigner. Les religieux mourraient l'un après l'autre jusqu'à complète extinction et leurs biens deviendraient propriété de l'Etat.

Pareille décision constituait un grand changement pour les Canadiens français, et exigeait de nouveaux arrangements. James Murray, le gouverneur, comprit la situation. Il vit que les Canadiens français avaient besoin d'un clergé, et donc d'un évêque et d'un séminaire et il permit au Séminaire de Québec de continuer à donner l'enseignement. Celui de théologie avait été partiellement interrompu par la guerre; on le reprit en le complétant. Pour les classiques, le séminaire recueillit la succession des Jésuites, succession complète avec livres, ma-

nuels, programmes, méthodes, etc. Les prêtres qui composaient le Séminaire de Québec avaient été élèves des Jésuites, soit à Québec, soit en Europe. Après le bombardement, le séminaire rouvrit ses portes en 1765 et cette fois avec les études classiques chez lui. Désormais on accueillerait tous les jeunes gens, même ceux qui ne songeaient pas à se faire prêtres; il devint un collège au lieu de seulement un séminaire. Ce fut une rude tâche pour les ecclésiastiques de cette maison mais ils la prirent avec ardeur et ils y excellèrent. Il voulurent donner un cours très solide et ils y parvinrent. L'examen final annuel des classes supérieures se tint en public. Il n'y avait pas de diplômes mais au moins une reconnaissance publique du talent et du succès. Après huit années consacrées à l'étude des langues, littératures classiques, de l'histoire et de la géographie, de la philosophie et des sciences, les jeunes gens pouvaient entrer dans l'administration, la politique, le commerce, le barreau, la médecine, la théologie, après y avoir donné soit les années d'études, soit les années d'apprentissage dans le cas du barreau et de la médecine.

Ne croyons pas, cependant, que l'idée d'université fut morte. Elle restait vivante dans les deux groupes —français et anglais. Les Canadiens français avaient une situation de faveur avec un collège classique et un séminaire théologique, sans compter les autres collèges classiques qui s'ouvrirent dans d'autres lieux. Les Canadiens anglais n'avaient que des écoles privées, l'affaire d'un seul maître; d'autre part, ils n'aimaient pas à envoyer leurs fils et leurs filles dans des écoles américaines. Pendant longtemps ils préférèrent les inscrire dans les collèges canadiens-français, particulièrement le séminaire et les ursulines.

Il semble bien que le groupe français aurait pu obtenir facilement une université en 1774, avec l'Acte de Québec. Ils eurent alors confirmation de leur droit de rester catholiques, de leur droit au régime seigneurial, aux dîmes, et, ce qui est plus, la dispense du serment du test. Toutes ces concessions furent de durs sacrifices pour la Grande-Bretagne, pays décidément protestant. Le Gouverneur Carleton et le French Party contribuèrent à ces largesses. Par conséquent, si les Canadiens français avaient demandé une université complète, ils l'auraient eue mais ils ne la demandèrent pas.

Plus tard, l'élément anglais voulut une université. Ils imaginèrent une sorte d'université d'état qui serait neutre en religion; tous les élèves auraient suivi les mêmes cours, sauf en théologie, où on aurait eu deux collèges séparés—un protestant et un catholique. Les Catholiques n'aimaient pas la neutralité et les Non-Conformistes abhorraient l'idée d'une théologie anglicane. Le project, légalisé sous le nom d'Institution Royale, deviendrait le McGill Collège, grâce à un legs de James McGill à Montréal. L'Institution McGill commença comme simple collège des arts tout comme jadis le collège des Jésuites et la Séminaire de Québec. On en dira autant du King's College devenu l'université de Toronto et d'autres universités canadiennes.

Le besoin d'une université se faisait sentir de plus en plus, surtout avec l'organisation du Barreau et celle du Bureau d'Examinateurs en Médecine, puis avec la venue de médecins et d'avocats des Iles Britanniques; puis avec la naissance de plusieurs écoles de médecine aux Etats-Unis; puis lorsque McGill obtint une charte avec pouvoir de conférer les grades universitaires. Retenons ces raisons. Mais d'autres raisons encore incitaient le groupe français à créer une université. La principale se trouve dans le Rapport Durham. Il se peut que, comme la plupart des Canadiens, vous n'ayez pas lu ce rapport qui a si fortement influencé le développement du Canada. Et pourtant j'estime que tous les Canadiens instruits devraient le lire. Le gouvernement de Grande-Bretagne envoya Durham au Canada en 1838 pour apaiser la rébellion qui sévissait dans le Haut et dans le Bas-Canada. Durham procéda à des enquêtes élaborées, soit par lui-même, soit par ses agents. Il présenta son rapport à la Chambre des Com-

munes de Londres en janvier 1839. Ce fut être un scandale pour le gouvernement britannique car Durham n'avait que des blâmes pour ce gouvernement et pour le groupe anglais du Canada il avait autant de blâmes que de louanges. Quant aux Canadiens français il les louait clairement dans la première partie mais il les écorchait dans la seconde partie.

On en a retenu surtout un passage—celui où il dit que les Canadiens français sont un peuple sans histoire, sans littérature, sans théâtre, sans beaux-arts. Durham voulait dire qu'en fait les canadiens n'avaient pas encore écrit leur histoire, n'avaient encore produit ni littérature ni oeuvres dramatiques ni oeuvres d'art. Dans ce dernier cas l'erreur est manifeste ce qui est abondamment prouvé et par divers travaux de recherche historique et par cette exposition rétrospective des oeuvres d'art des anciens Canadiens français, que vous avez vue au Musée Provincial. Pour le reste, Durham avait raison. En effet, l'Histoire du Canada de Garneau n'avait pas encore paru.

Notre premier mouvement littéraire date de 1860; quant au drame il n'y en avait pas, pour la bonne raison que l'Eglise interdisait aux fidèles d'aller au théâtre. Durham n'a pas voulu dire que les Canadiens français manquaient de matières pour écrire des oeuvres historiques, littéraires, dramatiques. C'est pourtant l'intention que plusieurs Canadiens ont prêtée à Durham. Ils virent dans son rapport une condamnation finale à l'effet que le groupe français manquait de culture. Durham incluait, dans son rapport, des recommandations qui furent incorporées dans l'Acte d'Union de 1840. C'est alors que commença un suprême assaut contre les Canadiens français. La langue française perdit le caractère officiel qu'elle avait eu jusque-là; la religion catholique fut attaquée, surtout par la French-Canadian Missionary Society; le groupe française fut, dans le domaine administratif, mêlé au groupe anglais, afin de diminuer son importance numérique.

Ce fut une dure époque pour Jean-Baptiste mais on avait compté sans sa force de résistance. Quatre années à peine s'étaient écoulées depuis la parution du rapport de Durham, que le groupe français surgissait avec le plan d'une université, plan inspiré par la conviction que seule une université pourrait les sauver. Ce plan se fondait sur l'emploi des Biens des Jésuites. Il fut à l'étude environ quatre ans et on dut l'abandonner parce que, évidemment, le gouvernement anglais na céderait pas les Biens des Jésuites. Cet échec ne fit qu'aviver; chez les Canadiens français la volonté d'eriger une université. Ils tournérent alors leurs regards vers le Séminaire de Québec, cette ancienne corporation qui possécait des seigneuries, des exploitations agricoles, des maisons à loyer, et surtout qui jouissait de l'estime et du respect dè tous à cause de sa haute valeur académique. Le séminaire céda à la pression; le gouverneur anglais l'appuya; la Reine Victoria accorda une charte universitaire en 1852. Ces faits vous feront comprendre, je crois, quelle importance les Canadiens français donnent au Centenaire de cette charte. On voit, maintenant, combien nos pères eurent raison de penser que le salut du groupe résidait dans l'oeuvre universitaire. Aujourd'hui, il est aisé de voir tout ce qui s'est produit pendant ces cent années de l'université. Littérature, histoire, philosophie, et sciences sont en pleine production. Des milliers de jeunes gens et jeunes filles se préparent chaque année à plus de cinquante carrières; les diplomés de Laval sont recherchés.

L'une de ces carrières est celle de l'infirmière. A première vue elle est assez récente dans l'université puisque la première affiliation est de 1923 et que les premiers cours pour le baccalauréat en sciences hospitalières datent de 1933. Mais n'oublions pas les faits historiques.

La carrière d'infirmière est aussi ancienne que la Nouvelle-France. Officiellement la colonie française commença avec la fondation de Québec en 1608; mais son état resta très précaire jusqu'en 1633. Il se produisit alors un recommencement, consécutif au Traité de St-Germain-en-Laye de 1632. Six

ans plus tard arrivèrent de France les premières infirmières qui ouvrirent le premier hôpital à Québec, l'Hôtel-Dieu—qui existe encore; audacieuse entreprise, aussi hardie que la fondation d'un collège classique par les Jésuites quatre ans plutôt, car la population était encore faible et clairsemée. N'oublions pas que ces religieuses de l'Hôtel-Dieu n'avaient pas d'autre occupation que le soin des malades; l'enseignement était réservé aux ursulines. Ces infirmières, à coup sûr, n'avaient pas de diplôme universitaire, pas d'autre diplôme que leur bonne volonté et une instruction générale. Pour le côté technique de leur travail, elles prenaient conseil des médecins, chirurgiens et apothicaires de l'époque. L'un de ces hommes était le médecin principal de l'hôpital mais les autres étaient admis à traiter leurs patients. Les registres de l'Hôtel-Dieu montrent que même les médecins des navires en rade étaient admis à cet hôpital. La rudesse du climat, les épidémies fréquentes, les marins venus de partout offraient une suffisante variété de cas à traiter. Médecins et chirurgiens y trouvèrent leur avantage, ainsi que les jeunes en apprentissage. Plus tard s'ouvrit l'Hôpital Général puis, sous le régime anglais, l'Hôpital de la Marine et enfin l'Asile des Aliénés.

Les religieuses infirmières de l'Hôtel-Dieu se tinrent en relations étroites avec les Jésuites d'abord, puis avec le Séminaire de Québec. C'est un prêtre de ce séminaire qui, d'ordinaire, était l'aviseur spirituel, et même le conseiller général, des Soeurs. Séminaire, Collège des Jésuites, Ursulines, Hôtel-Dieu formaient une sorte de coopérative pour les achats en France. Les cahiers de comptes du séminaire ont d'étonnants détails—par example, quantité d'articles féminins, qui évidemment étaient pour les réligieuses, car le séminaire avait très peu de femmes à son emploi.

Lorsque la Faculté de Médecine fut ouverte en 1854, les relations entre les infirmières de l'Hôtel-Dieu et les professeurs de médecine se firent plus actives; de bonne heure s'ouvrirent les cliniques; médecins et infirmières collaboraient volontiers avec succès.

Lors des premières affiliations d'écoles d'infirmières (1923) les religieuses redoutèrent un peu cette nouvelle invention, qui semblait attaquer leurs vénérables traditions. Sept écoles furent affiliées avant que l'Hôtel-Dieu ne bougeât; mais en 1933 il se prévalut de cet advantage et entra dans la carrière résolument. Les Soeurs acceptèrent aussitôt la proposition, que je leur fis en 1933, de faire donner des cours supérieurs et c'est à l'Hôtel-Dieu que ces cours se donnèrent pour la première fois l'hiver de 1934. Environ 20 religieuses de diverses communautés suivirent ces cours. Aujourd'hui l'Université Laval compte 15 écoles d'infirmières pour le cours ordinaire. Ajoutons des cours spéciaux en chirurgie, en obstétrique et gynécologie, en physiologie. La Faculté de Médecine contrôle ces derniers enseignements, avec l'aide de quelques officiers d'administration. Ces écoles et ces cours desservent tout près de mille élèves.

Il y aurait beaucoup à dire sur l'attitude des infirmières canadiennes-françaises à l'égard des diverses associations professionnelles d'infirmières mais je me garderai d'en parler, car ce sujet est épineux et il y faudrait de longues considérations.

La plupart d'entre vous sont de langue anglaise et je présume qu'elles aimeraient connaître les relations entre l'Université Laval et les Canadiens de langue anglaise. Ces relations ont toujours été amicales. Même avant la charte universitaire c'était la coutume, au Séminaire de Québec, d'accepter bon nombre d'élèves de langue anglaise. Lors de l'ouverture des cours en 1854, de jeunes Anglo-Canadiens s'inscrivirent en droit, en médecine et aux arts, particulièrement pour la pharmacie. Ils formèrent environ le quart de la population étudiante. Cette pratique s'est toujours continuée. Elle est encore notable; elle est même très remarquable aux cours d'été. On ne saurait trouver, dans cette Université Laval, la moindre trace d'étroitesse d'esprit en ce domaine. Au contraire, il y eut toujours bonne volonté de coopération. L'Uni-

versité Laval favorise énergiquement le bilinguisme et la double culture pour tout le Canada. On vient d'en voir un bel exemple à Québec dans le congrès de la Fondation Hazen. Ce congrès a réuni 50 members, tous assez bilingues pour se comprendre dans l'une ou l'autre langue. Tous des professeurs d'université et de diverses disciplines venus discuter les mêmes problèmes sous différents angles. On a dit de ce congrès que c'était "un petit Canada idéal" et que de telles assises sont le meilleur moyen de crée l'Entente Nationale.

Il reste, certes, beaucoup de chemin à parcourir avant d'arriver à une parfaite entente entre les deux principaux groupes du Canada. Il y a encore des préjugés à dissiper mais la lumière viendra. Elle vient déjà; l'idée d'un Canada bi-culturel se répand très vite.

Votre association peut en cela faire sa part et une part de premier plan. Essayez d'en arriver au point où tous les membres seront bilingues où, dans vos discussions et rapports, l'une et l'autre langue seront sur le même pied. Tout Canadien instruit—et vous l'êtes toutes—devrait étudier les préjugés qui bloquent encore la voie vers une véritable Entente Nationale.

Votre premier devoir est de soigner l'humanité souffrante; mais vous êtes citoyennes d'un pays et à ce titre vous devez contribuer à la formation d'une grande nation et évidemment je veux dire la Nation Canadienne.

Drug Addiction in Canada

An old problem that has been brought into sharp relief in recent months is the incidence of narcotic addiction. It is not possible to obtain a satisfactory estimate of the number of drug addicts in Canada nor in any part of it. Some 4,800 persons who have been convicted on a drug charge are known to be free at the present time to continue their addiction. No formula has been devised to estimate the number of possible addicts from our knowledge of the number of convicted addicts.

Endeavoring to find some favorable means of combatting this problem, especially in view of the publicity that has been given to the rising incidence of drug addiction among adolescents, citizens' groups are being alerted to the dangers. In Vancouver, particularly, a special committee on narcotics has been organized under the auspices of the Community Chest and Council. Literature setting out the problem and a suggested solution is being made available. The co-operation of organizations is being urged to help arouse public opinion generally. The support of the nursing profession, both through the associations and as individuals, is being sought.

Basically, narcotic addiction is a medical problem with definite psychiatric implications. Dr. Edward A. Strecker in his book "Fundamentals of Psychiatry" notes:

> In drug addiction . . . the individuals have resorted to an unreality produced by the drug, since they cannot face life at the level of sober, unnarcotized, mature, adult responsibility. Unconsciously, they seek to blur rosily the rigid and unrelenting outlines of reality and eventually to annihilate reality altogether.

Dr. Lawrence E. Ranta, chairman of the Narcotics Committee in Vancouver, has written:

> Habituation to a narcotic drug arises when an individual takes a sufficient number of doses of a narcotic drug to have his body begin to depend upon its presence. This physiological dependency may occur if the drug is consumed by mouth, inhaled into the nose, or taken with a needle under the skin or into a vein.
>
> Before the chemical mechanism of his body begins to depend upon the presence of the drug in order to maintain normalcy, the individual may demand the drug only as a psychological "prop." The drug may be used at first merely to assist the individual to withstand the normal pressures of

life if that individual finds himself psychologically unable to cope with normal situations.

Others may avail themselves of an opportunity to acquire the drug and use it as a shield against the "slings and arrows of outrageous fortune." Still others may "stumble" into addiction through failure to recognize the dangers of drugs, while some may be lured into addiction by bravado or by the pernicious challenge of being a "good sport." Maladjustments to social and emotional situations may, then, play a major part in the development of habituation.

Once addicted, in a psychological sense, the addict is incapable of normal or seemingly normal action without periodic and daily recourse to the drug of his addiction or to a suitable drug substitute.

As soon as the effects of the last dose begin to wear off, the nervous system of the addict awakens to a demand for the drug, expressed by a state of irritability and over-sensitivity.

Denial of the drug for even as short a period as 24 hours may induce "withdrawal" symptoms. With their severity somewhat dependent upon the size of the dosage to which the individual is addicted, these symptoms include a sense of severe restlessness, apprehension, and depression.

Yawning and stretching and frequent sneezing are some of the signs of the addict's physiological dependence upon his drug. His hands shake. He trembles violently. He sweats and vomits. Cramps in agonizing spasms tear at his abdomen and at the muscles of his legs until he virtually collapses. These symptoms may last in violent severity for two or three days, gradually disappearing over a week to 10 days.

In the course of these "withdrawal" symptoms, the administration of the drug completely and almost instantly transforms the "Hyde" of abstinence into the "Jekyll" of affability. He becomes contented, superior, good-natured, disdainful of truth and reality, and too full of procrastination. In this state the addict is outwardly normal. His reaction times are, however, depressed. He is prone to accidents and menaces himself and others in an age of mechanization. The world of reality is, on the whole, too fast for him, physically and emotionally.

In the course of habituation, the addict finds that his requirements increase. He is tempted to permit himself a slightly increased dosage above his usual requirement. The dosage may increase in frequency and in quantity until several grains are required to achieve the results previously achieved by a fraction of a grain. Now, physically harrassed, the addict takes four or five doses of narcotic drug daily.

Eventually, with an average addiction-life of little more than a score of years, the addict may die of pneumonia, from the long-term effects of intermittent skin infection upon his kidneys, or by accident, but rarely by suicide, since the exhaustion of his nervous system seems even to deprive him of this final assertion of will.

Though this side of the problem is serious enough, there is another and more dreadful side that also must be considered in connection with drug addiction. Dr. Ranta states that:

> As an addict is unable to maintain his addiction and still make enough money by legal means to pay for his supply of drug, he usually resorts to crime. Male addicts undertake thieving of major or minor nature, while female addicts take to shoplifting and prostitution.
>
> The volume of crime initiated by drug addiction results in increasing numbers of jail sentences and raises the costs for penal institutions. The costs of incarceration must be considered high since there is no evidence that jail sentences cure addicts. On the contrary, the lack of segregation of addicts from non-addicts results in a recruitment of drug users.
>
> The existence of the social abscess of drug addiction in any community remains a perpetual threat to the less stable or less knowledgeable elements of the community. By strong police action the availability of illicit drugs is decreased to some extent. The demand

is high and, consequently, the cost of illegal drugs mounts. With possibilities of great profits, criminal forces trading in drugs take desperate chances. Large profits encourage the recruitment of handlers since, if the handler is apprehended, he may expect "to take his holiday (in jail) with pay." The penalties that he may receive upon conviction have been relatively light in view of the malignant nature of the crime. Though the maximum penalty is seven years' imprisonment with a $1,000 fine and lashes, the sentences have frequently tended to approach the minimum of 9 to 12 months' imprisonment and a $200 fine.

Every nurse knows that the various narcotic drugs, when used for medicinal purposes, have an important role in the prevention of pain. The supply for these legally recognized purposes is not limited though, obviously, some form of control must be provided in the form of the narcotic registers maintained in every ward.

The methods used by the law enforcement agencies to control the supply in order to prevent narcotics from reaching the hands of addicts have centred in the supervision of the manufacturing plants and keeping a watch for imported supplies. That they are unsuccessful is obvious. It is reputed that the British system of control, in contrast, has been decidedly effective in minimizing their problem:

In Britain it is possible for the physician to give ambulatory treatment to the addict, even over a long period of time. This may result in complete withdrawal of the drug without the inhumanity of "withdrawal" symptoms or, at least, maintenance of the addict's dosage at a low and safe level commensurate with some degree of a normal and useful life.

Several other countries also concentrate their punitive activities against illegal traffic but look upon the addict as a medical problem. Thus, Norway, Sweden, Denmark, Netherlands, Belgium, France, Switzerland, Austria, Italy, Australia, and New Zealand number their addicts in the hundreds or less. For example, in 1949, with a population of 1,902,000, New Zealand estimated her addict population at 45!

These countries are virtually free from the illegal drug traffic. They even have difficulty in understanding our concept of the criminal addict, for their addicts are not driven to crime in order to support their addiction.

Plans for the control of narcotic addiction in Canada call for the support of every citizen. Be informed yourselves and join with the groups that are working for the ultimate disappearance of this menace from our communities.

Flying Down to Rio

If you hear strange syllables coming from the lips of your colleagues this winter, do not be surprised. You will be able to guess that they are among the lucky group who are practising a few sentences in Portuguese preparatory to attending the I.C.N. Congress in Rio de Janeiro next July.

Already the Canadian Nurses' Association has appointed Thos. Cook & Son as the official travel agents for this occasion. Preliminary information regarding tours is now available. Though the prices quoted must be considered tentative until the 1953 rates are released by the various airlines, it would appear that it will cost approximately $1,100 for the return trip by air from Montreal. A conducted tour, at approximately $1,675 per person, is being planned that will include round trip air transportation, hotels (excepting in Rio de Janeiro), and sight-seeing in Trinadad, Brazil, Uruguay, Argentine, Chile, Peru, Panama, and Jamaica. More complete details of itineraries will be published later.

To be faithful in little things is a proof of a noble mind; ungenerosity is the fruit of a narrow mind, as is also ingratitude.—M. ARMSTRONG.

Trends in Nursing

International Council of Nurses

The Nursing Service Committee, which has been studying acceptable standards of nursing service, has forwarded papers from working groups in 15 different countries to the various member associations for their comments. General discussion will undoubtedly take place at the International Council of Nurses Tenth Quadrennial Congress in Rio de Janeiro on July 13, 1953.

The I.C.N. Newsletter

Miss Alice C. Sher, assistant secretary of the I.C.N., and president of the International Nurses' Screening Board, reports that during May, June, and July, 384 letters have been sent out from I.C.N. headquarters on behalf of refugee nurses and others wishing to have their credentials established. As a result of information supplied, 40 cases have been accepted for registration.

Mention was made of an International Hospitals Directory (Section A - D). This Directory, when completed, will give the names and addresses of all hospitals in countries affiliated to the I.H.F. and pertinent information concerning each. The Directory can be obtained from the following address:

Captain J. E. Stone, M.C.
Honorary Secretary
International Hospital Federation
King Edward's Hospital Fund for London
10 Old Jewry, London, E.C.2, England.

Great Britain: Word comes of two conferences in June, sponsored by the National Council of Nurses of Great Britain and Northern Ireland. One, particularly for secretaries of associations affiliated to the National Council of Nurses, included lectures on Committee Procedure and Public Speaking and talks on the I.C.N. and F.N.I.F. by their respective leaders. The other, a pediatric conference sponsored jointly by the N.C.N. and the Association of Sick Children's Hospital Nurses of Great Britain, was widely attended by many British nurses and by representatives from 12 other countries. It consisted of a wide variety of lectures, demonstrations, and visits.

At the summer school organized by the Old Internationals' Association and held at Bedford College, London, July 10 - 18, the main subject of discussion was "Human Relationships in International Nursing Affairs."

Korea: The response to the appeal in May for textbooks and teaching equipment for the nursing schools in Korea has been good. Great Britain and New Zealand were noted, particularly for their contributions of anatomical charts, books, and periodicals.

Iceland: In June the Board of Directors of the Northern Nurses' Association (a federation of the nurses' associations in Norway, Sweden, Denmark, Finland, and Iceland) flew by special plane from Oslo to Reykjavik, Iceland, for their meeting.

Taiwan: The Nurses' Association of China, re-organised in Taiwan, has as its president, Miss Mei-Yu-Chow, dean of nursing of the National Defence Medical Centre. The association has 298 members registered. Miss Mei-Yu-Chow said in appreciation of the encouragement given her by I.C.N. member associations: "All these international relationships make us feel that we have come back to the big family again." Miss Stella Chen, principal of the school of nursing of Taiwan University Hospital, was able to attend the Study Week in New Zealand in March. Miss Chen will be remembered by many Canadians who met her here in 1949.

Florence Nightingale International Foundation

Miss Ellen Broe, director of the Foundation, reports that she spent a day in Cambridge visiting the new Institute on Human Ecology and University Health Service. This is the first chair ever established in Human Ecology (the study of the reaction of the human organism to his environment).

The F.N.I.F. is continuing with its

study of Advanced Programs in Nursing Education for WHO. Miss Broe plans to visit post-basic schools in Belgium, Germany, and possibly the Middle East, before Christmas.

The Expert Committee on Nursing of WHO

Attention is drawn to the second report of the Expert Committee on Nursing of WHO. The function of the committee is particularly directed to the consideration of the provision of nursing and the preparation of nursing personnel in those areas of the world where they are scarce or not immediately available and where the universal health needs are not met—food, shelter, clothing, provision of good health procedures, etc. It stresses the fallacy of attempting to superimpose a curriculum, found successful in one culture, upon another culture where the circumstances of training differ to a marked degree.

Maternity Protection

At the session of the International Labour Conference in Geneva in June, the Maternity Protection Convention was revised. This convention relates to safeguards during the maternity period for women employed in industry and in most non-industrial occupations. It has been broadened to include agricultural and domestic workers. The total maternity leave period of 12 weeks has not been changed but has been made more flexible so that as long as the post-natal leave period is at least six weeks, there may be variation in the length of prenatal leave. Provisions relating to cash benefits have been made more precise.

Orientation et Tendances en Nursing

LE CONSEIL INTERNATIONAL DES INFIRMIÈRES

Quelles sont les normes en nursing? Un comité spécial, après avoir étudié la question, a formulé des normes généralement acceptables. Quinze différents pays, à leur tour, étudiront ces normes et feront des commentaires appropriés. Il y aura une discussion générale, sur ce sujet, lors du Congrès International des Infirmières à Rio-de-Janeiro le 13 juillet 1953.

BULLETIN DE NOUVELLE DU C.I.I.

Mlle Alice C. Sher, assistante secrétaire du C.I.I., et présidente du Comité International de Sélection des Infirmières, rapporte que durant les mois de mai, juin et juillet, 384 lettres furent écrites à des réfugiées et autres personnes désirant faire évaluer leur dossier en vue d'être reconnues comme infirmières. Après avoir étudié les renseignements donnés, 40 furent acceptées comme infirmières.

Dans la même bulletin, l'on mentionnait la publication d'un Répertoire International des Hôpitaux (Section A-D). Ce répertoire, une fois complété, donnera le nom et adresse de tous les hôpitaux des pays affiliés à la Fédération Internationale des Hôpitaux. Pour plus de renseignements s'adresser à: *Capitain J. E. Stone, M.C., Honorary Secretary, International Hospital Federation, 10 Old Jewry, London, E.C. 2, England.*

Grande-Bretagne: Deux conférences eurent lieu en juin sous les auspices du "National Council of Nurses" de Grande-Bretagne. La première s'adresse aux secrétaires des associations affiliées au N.C.N. et porta sur les procédures parlementaire et l'art oratoire. Des conférences furent données sur le Conseil International des Infirmières et sur la Fondation Internationale Florence Nightingale. La pédiatrie fut l'objet de la deuxième conférence organisée conjointement par N.C.N. et les infirmières des hôpitaux d'enfants de Grande-Bretagne. L'assistance fut remarquable et l'on compta des représentantes de douze pays étrangers.

Corée: L'appel lancé en faveur des écoles d'infirmières de Corée reçut une bonne réponse. Des manuels et des fournitures scolaires, planches anatomiques et revues furent envoyés. La générosité de la Grande-Bretagne et de la Nouvelle-Zélande mérite d'être mentionnée.

L'Islande: Les Comités de Régie des as-

sociations des infirmières de Suède, Norvège, Danemark, Finlande et d'Islande se réuniront à Reykjavik.

Chine: L'Association des Infirmières de Chine s'est réorganisée à Taiwan. La présidente élue est Mlle Mei-Yu-Chow, directrice du nursing au Centre National de la Défense. L'association compte 298 membres. Manifestant sa reconnaissance envers le C.I.I., la présidente disait: "Ces relations internationales nous donnent l'impression d'un retour au sein de la famille."

Plusieurs infirmières canadiennes se rappelent de Mlle Stella Chen qui était avec nous en 1949. Maintenant elle occupe le poste de principale de l'école d'infirmières de l'Hôpital de l'Université de Taiwan.

Fondation Internationale Florence Nightingale

Mlle Ellen Broe, directrice de la Fondation, rapporte qu'elle a passé une journée à Cambridge à visiter l'"Institute on Human Ecology" et le Service de Santé de l'université. L'on entend par "Human Ecology" l'étude des réactions de l'organisme humain à son environnement. L'université possède la première chaire dans cette science.

Protection Maternelle

Lors d'une séance de la Conférence Internationale du Travail à Genève en juin dernier, la convention concernant la protection maternelle fut revisée. La convention contient les mesures prises pour protéger les femmes employées en industries ou ailleurs durant leur grossesse. La convention s'étend maintenant aux ouvrières agricoles et aux domestiques. Le congé de maternité demeure de douze semaines mais peut s'étendre aussi bien à la période prénatale que post-natale. Cette dernière doit être au minimum de six semaines. Les dispositions concernant les allocations en espèces ont été précisées.

Le Comité d'Experts des Soins Infirmières de O.M.S.

Le second rapport du comité vient d'être publié. Le comité estime que sa tâche consiste d'étudier la façon dont les soins infirmiers sont assurés et la formation du personnel infirmier, en tenant compte tout particulièrement des régions qui souffrent d'une pénurie de ce personnel et où les besoins sanitaires indispensables de la population n'ont pas été satisfaits. Le comité appui sur l'inutilité de tenter d'appliquer dans certains pays un programme d'études qui a été élaboré pour d'autres niveaux culturels. Il risque de n'être guère efficace et il pourrait même faire obstacle à l'adoption d'un programme de caractère plus réaliste.

Hundred-Year-Old Problem

Miss Nightingale insisted that training must consist of two branches, each equally important—the training of the mind and the training of the character. The training of the mind can be done by classes and lectures and tested by examination but the training of character can only be done by personal contact and personal teaching and the only possible proof is a testimonial from personal knowledge. This is where Miss Nightingale ran into serious difficulty. . . Everyone was asking for trained nurses and it was said that the form of training she laid down, the exactions and the close supervision, of her method, could not possibly produce nurses by the thousands as they were now urgently needed. It was never suggested that her results were not superior, only that it was impossible that her method should meet the demand. She was urged to enlarge the Nightingale Training School; to start new schools; to lower the standard, temporarily at least; not to be so particular about the girls she took. She refused. She would not let her standard down; she took a very long view. She remarked dryly that people expected great things to be done in six months whereas it was essentially the work of centuries. Nevertheless, real difficulty existed and a number of people felt that it was a pity that the production of nurses should be so small when the need was great.

—C. Woodham-Smith

in *The Nightingale Fellowship Journal.*

Student Nurses

Ligatures and Sutures

BETTY MARTIN

Ligatures and sutures have been used since the beginning of medical history. Today they form a complex and varied part of the surgeon's equipment in the operating room.

A ligature is a strand of material, usually the same as that used for sutures, with which vessels are tied off or constricted to prevent hemorrhage.

A suture is a strand of thread used with a needle to approximate or bring tissues together to promote healing. There are two types of sutures—absorbable and non-absorbable. The absorbable sutures are those which are absorbed in the tissues during the process of healing; the non-absorbable are threads not absorbed during the healing process but which remain indefinitely in the tissues, sometimes becoming encapsulated.

In the evolution of surgery certain substances have been proven to be of better quality and have been adopted for use as sutures by the surgeons of today. The most common absorbable sutures are surgical gut, Kangaroo tendon and Ribbon Gut, while the non-absorbable are silk, silkworm gut, Dermalon or monofilament nylon, Surgilon or braided nylon, linen, cotton, horsehair, and surgaloy or wire. Modern surgical catgut is prepared from longitudinally split segments of submucous connective tissue of the upper third of the small intestine of government inspected sheep. Freshly removed intestines are cleaned, conditioned and split lengthwise into strips. After other layers are removed these strips are twisted spirally to form a cord or strand. The gut manufacturing centres of today are located near large slaughter houses in order to prevent the deterioration that might lessen the quality of the gut produced.

The name *catgut* is now used because earlier the gut was the same as was used on the fiddle, known as kitstring. Hence from "kit" has come "cat" or catgut. Since catgut is made up of animal protein, collagen, it is readily absorbable in the tissues. To delay absorption, as the surgeon sometimes wants to be sure the wound is sufficiently healed before the gut is absorbed, the catgut can undergo a chromic processing which combines with the collagen and delays absorption in the wound. This result is obtained because the chromic salts are resistant to the enzyme action of tissue cells. Catgut can be mild chromic, medium and extra chromic, depending on the surgeon's requirements. In both chromic and plain catgut the sizes range from very fine thread, such as five 0, getting coarser as it graduates to size one or two. Plain gut is absorbed in approximately five days. Absorption takes place more rapidly in infected tissues than in normal tissues due to the excessive phagocytic reaction which digests the foreign protein. In the repair of the cervix or vagina, either chromic or plain gut may be absorbed much more quickly because of the digestive action of enzymes present in the cervical and vaginal secretion. In the tissues of a lacerated perineum also there may be markedly increased cellular activity, thus increasing absorption.

Catgut should not pass through the skin because stitch abscesses are likely to result due to organisms present in the deeper structures of the skin. *Ribbon Gut Suture* is flat absorbable gut, five-eighths of an inch wide and 18 inches long. It is a flat strip of intestinal suture instead of being a cord twisted spirally. Because of its width this suture distributes pres-

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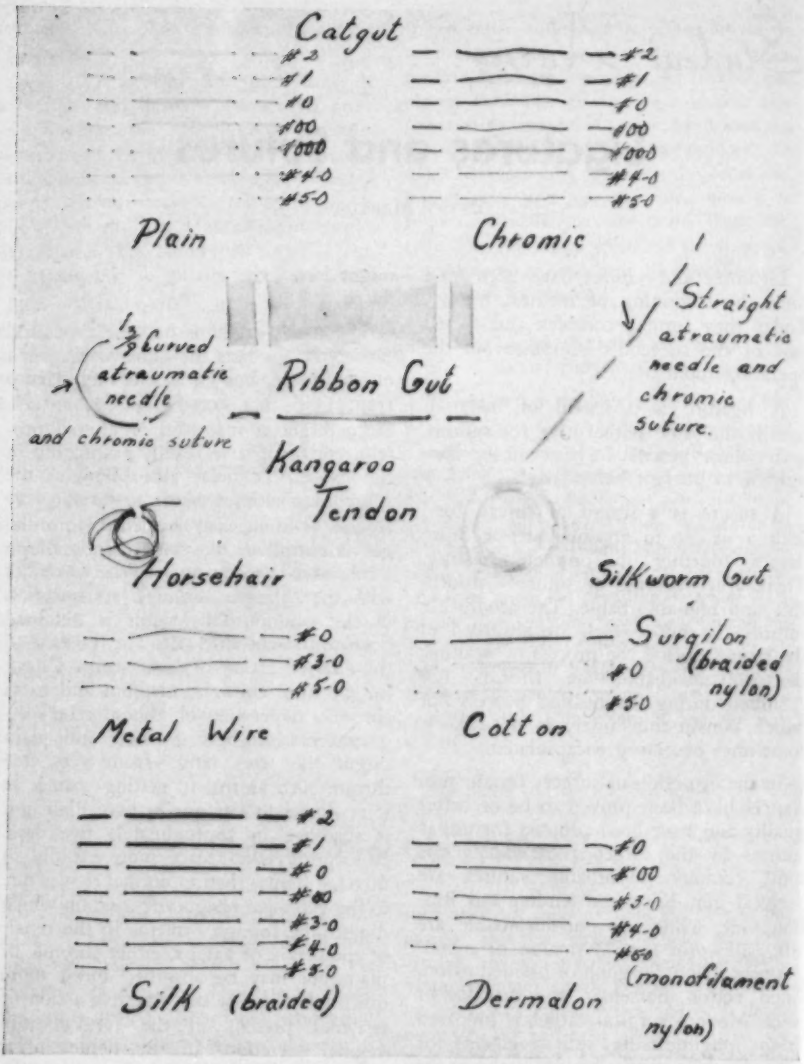

sure over a broad surface, permitting the application of tension to delicate tissues without cutting through and with a minimum of circulatory constriction. It can be readily tied into a knot which does not slip and is usually supplied as chromic. On delicate tissues, such as damaged liver or kidney tissue, this suture is very useful. Before using, ribbon gut should be fully unwound and immersed in a warm sterile solution to render it soft and pliable, actually gaining in tensile strength with continued immersion.

Kangaroo Tendon comes from the tail of the small kangaroo or wallaby. The tendon bundle from a freshly killed animal is air-dried by the trapper and then separated into its individual tendons of various diameters. These individual tendons are used for sutures and ligatures, after having been chromicized. Animal tendon consists of compact longitudinal fibres in their natural state which have never been separated and for

this reason they absorb more slowly and more perfectly than spiral strands of gut. Smaller tendons are used in the radical cure of hernia, while the larger sizes are employed in bone surgery.

Silk is probably the best known non-absorbable suture material consisting of thread prepared from the cocoon spun by the silkworm. Strands are processed to form threads of various diameters by either braiding or twisting. Silk is used for permanent sutures and may become encapsulated. Because of its exceeding pliability and ease of handling, silk is often used in surgery of the gastro-intestinal tract, eye, tendons, thyroid, nerves, and arteries. Anacap braided silk is non-capillary, non-irritating to tissues, ties readily in a firm knot which does not slip. This type retains all the smoothness and flexibility of natural untreated silk, is not affected by boiling or autoclaving, by action of tissue fluids, antiseptics or irrigating solutions.

Kal-dermic is made up of a basic strand of parallel silk fibres encased in a modified protein coating, rendering it resistant to the action of body fluids. Kal-dermic is used mainly for skin and tension sutures.

Silkworm gut is from the thick fluid secreted by the silkworm. When the worm is ripe for spinning, it is killed and the two gelatinous sacks of the intestines are stretched from end to end. These quickly harden into a thread of average length. This gut is used chiefly for skin and tension sutures.

Dermalon for skin and tension sutures is processed from the nylon monofilament. Smooth, uniformly round, unaffected by tissue fluids, and free from irritative properties, it makes an excellent skin suture.

Surgilon sutures are strands of braided nylon filament. Flexibility and adequate strength, added to the fact that a minimum of tissue reaction is produced, give Surgilon a wide range of application as a buried suture.

Surgical cotton is a vegetable fibre spun from long fibre cotton of exceptional tensile strength, uniformity of diameter and smoothness of texture.

Linen, impregnated with celluloid, is employed chiefly in intestinal surgery.

Horsehair, secured from the tail of a horse, is light, flexible, elastic, and is used principally in cosmetic surgery.

Surgaloy, metallic sutures of stainless steel wire and of exceptional strength, flexible, non-corrosive, inert, is well tolerated by tissues. There are two types, monostrand and multistrand, used in all types of surgery.

All of these threads may be used as either primary, interrupted, continuous, or stay and tension sutures.

A *primary* suture is the one sewn to approximate the tissues at the incisional line and can be either continuous or interrupted. An *interrupted* suture is one in which each stitch is self-contained and tied independently of the other stitches. A *continuous* suture runs continuously from one stitch to another and only the first and last stitches of the series are tied. A *stay or tension* suture is of non-absorbable material inserted at a distance from the edges of the wound and passed through the skin, subcutaneous tissue, anterior sheath and portion of muscle. Used to offset forces tending to separate the edges of the wound, it acts as a secondary line of defence in case an unusual amount of tension is thrown on the primary suture line. Tension sutures are used in abdominal surgery, with Dermalon, Surgilon, Silkworm Gut and wire being employed.

The types of sutures that have been discussed have had to fulfil the following qualities before being adapted for use by surgeons:

1. Sterile and free from irritating qualities.
2. Possess fine gauge coupled with sufficient tensile strength to hold the wound edges in perfect apposition.
3. Remain in the tissues when and where placed, supporting them until strong enough to go unsupported.
4. Be absorbed as soon as their job is done, otherwise remain orderly and peaceful where the surgeon has placed them.
5. Be pliable enough to tie easily yet hold the knot securely.

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Perfume and Toilet Water

W. Schweisheimer, M.D.

Once, at an international medical congress, a nurse asked one of the dermatologists to have a look at her face. He happened to be a German doctor and he said, "That seems to be a *dermatitis des rinnenden Tropfens.*" A French colleague, with whom he was conversing, confirmed the diagnosis by stating: "We call it *dermatite pigmentée en forme de coulée.*" If an American or British doctor had been present, he would have said, "Indeed, this is a case of perfume dermatitis."

They all meant the same thing. Dermatitis due to perfume is more common than is generally assumed. The perfume may be part of a nail polish, a toilet water, or a hair lacquer. Perfume dermatitis as a rule affects only circumscribed parts of the body —those parts with which the perfume or lacquer has been in touch. This is obvious in the German name *dermatitis des rinnenden Tropfens* which actually means an inflammation of the skin along the track which a running drop of perfume has left on the skin. Treatment of the skin condition must start with the avoidance of the irritant perfume or essential oil.

In Sickrooms

Spraying perfume is an excellent method of improving the air within a sickroom where one or several patients are suffering from chronic conditions of the bladder or the bowels, from bed-sores, or from a foul-smelling skin disease. No amount of airing or ventilation may be sufficient to remove bad odors from the patient's room in some instances. Consequently, perfumes are a welcome help and relief—welcome to both the patient and the nursing personnel.

A preparation containing oil of rosemary and other essential oils—eau-de-Cologne—may prove useful in nursing. It is added to the water used for washing or sponging the face, the hands and other parts of the bed-ridden patient. Most patients like the cooling and refreshing effect of the toilet water. A dilute solution of the preparation makes a quickly evaporating fluid out of which one or two layers of gauze may be wrung and applied to the forehead or an inflamed joint or bruised part, wherever the sensation of cooling is required. We are told by Clarkson that English nurses of Tudor times put the bruised fresh leaves of bergamot, mint, and lavender on the brows of their patients. For nervous headaches, the nurses of that era would apply herbal snuggs of basil alone or a combination of rosemary, betony, marjoram and lavender.

Pliny, a Roman naturalist in the first century A.D., recommended hanging pennyroyal in bedrooms because he considered it valuable for the health of the inmates. During the period of the Black Death—the Plague—in Europe odoriferous candles were used in sickrooms. They contained the essence of red roses, cloves, storax, labdanum, frankincense, citron peels, juniper berries, musk, ambergris, etc. The mixture was formed into long and small candles with gumdragant which had been dissolved in rose water.

Every substance used in the care of the skin, be it a lotion, a soap, cream, paste or whatever preparation seems most effective, generally has some perfume in it. Cleansing effects and stimulation of the blood vessels in the skin are the main points in this care but the addition of a perfume makes the method a pleasant one and guarantees its continuance. Perfumed soaps are in everybody's hands today—well to the advantage of the general health. This was not always so. We may remember Thackeray's word in "Pendennis" where somebody makes the caustic comment: "Gentlemen, there can be but little doubt that your ancestors were the great unwashed." Things have certainly changed for the better! Good Queen

Bess, in the 16th century, took only one bath a month. The longing for scented baths was great even then.

The pleasant scent of firs and pines in the warm rays of the sun produces a curative effect on the respiratory organs, soothing inflammation and catarrhs of bronchi and lungs. This fragrance is found in the pine-scented baths that give not only the welcome feeling of relaxation and care-free luxury but also are soothing for irritated nerves and after-work fatigue. Formerly fresh boughs of pines and firs were allowed to soak in warm water to produce this perfume. Nowadays extracted oils of pine, etc., and artificially produced chemical compounds are used.

The odor of the scented bath has a soothing and calming effect on many people. Other suitable perfumes for bath salts are the oils of citronella, lemongrass, lavender, rosemary, etc. Bath oils and essences, according to Bushby, are frequently made with a base of sulphonated caster oil or sulphonated olive oil. These act, without influencing the odor, as emulsifying agents when mixed with water and so prevent the oily rim which otherwise tends to form round the bath.

Perfumes and the scent of toilet water sometimes are able to help overcome a beginning irritation in nose, throat, and larynx, indicative of the onset of a cold. Several nurses I have known immediately poured some lavender water on their handkerchiefs whenever they felt the first sign of a head cold or sore throat. They were convinced that they could check the cold by inhaling from the handkerchief.

There is hardly any difference in medical efficiency between a natural perfume and a chemically prepared perfume. Chemists were successful in analyzing and building up, synthetically, quite a few of the frail substances, the combination of which is so characteristic of the odors of flowers. Many more shades and hues of fragrances are available today because of this development. Before the days of modern chemistry, there were only about 200 odors and flavors available to the perfumer. This number has increased to well over 1,000 since inventive chemists have created a whole new gamut of pleasant odors and flavors that do not exist in nature.

Care of Mouth and Breath

We hear much today of the unpleasantness of bad breath and its possible influence on the job of the sufferer. Constant reminders over the radio and in magazines keep the warning awake. Halitosis was recognized as an undesirable condition in ancient times; its presence excluded its victim from priesthood, made it impossible for a woman to nurse the sick.

Common causes of halitosis are: poor condition of the teeth, inflammation of the gums, chronically infected tonsils, nasal and sinus conditions. Decaying teeth and pyorrhea should be investigated. Some people are aware of bad breath on days when they are constipated, the trouble disappearing on days when their bowels have moved regularly. A perfumed mouthwash may well render the whole condition inoffensive though the actual cause has not yet been removed. This was well known to the Roman Emperor Nero who invited his friends to lavish meals but insisted that they used perfumed mouthwashes before coming to the table.

Most modern dentifrices and mouthwashes include one or several perfumes. Using a discreetly perfumed mouthwash several times a day, or an aromatic cachou or scented gum will at least mask and cover the unpleasant condition of bad breath. This not only gives a feeling of comfort and security but it may actually mean the difference between a job and unemployment in many occupations.

Pomander Balls

The first thing a nurse did when she went to the sickroom of a rich man in medieval times was to renew his *pomander*. This is an English word which comes from the French *pomme d'ambre*—apple or ball of amber. It was shaped like an apple, one of its

ingredients being ambergris. The pomander, on the average, was the size of a nutmeg and was made of perfumes and fragrant fixatives. It was first described by Pliny, early Roman naturalist. The scents used for its preparation in Pliny's day were: cinnamon, cassia, calamus, cardamom, balm, marjoram, myrrh, saffron, costus and storax, wild vine and betel nut. They were pounded and made into a paste with wine and honey and then enclosed in a gold or silver case studded with jewels and pierced with holes to emit the scent. Later, the receptacles became works of art. Pomanders were often hung from long silver chains about the neck or from the girdle. They enveloped the user in an aura of perfume.

Another job of the nurse in times when no real antiseptics were available was to strew herbs on the floor of sickrooms. Favorite was a mixture of hyssop, lavender, basil, tansy, balm and several mints. They were stirred and beaten so that a wholesome cloud of fragrance drifted out into the air—pleasure as well as protection for both patient and nurse.

Annual Meeting in Alberta

Banff was the setting for the 34th annual meeting of the Alberta Association of Registered Nurses, May 19-21, 1952, when the president, Miss Frances Ferguson, was in the chair.

Father Mackay opened the meetings on Monday morning with the invocation, followed by messages of welcome from the Park superintendent, Mr. Coleman, and Mr. Cameron, director of the School of Fine Arts.

The president welcomed the members and the 17 student nurses, stressing the positive effects of working together with goodwill, using the quotation: "Goodwill is . . . as powerful as a great turbine and as hard to build, as wonderful to use and as hard to keep."

Salient points in the report of the registrar were:

1. That the projected plan for the appointment of a full-time adviser to schools of nursing had to be dropped, as financial help from the government had not been obtainable.

2. In an effort to establish closer liaison between the A.A.R.N. and the University of Alberta, the General Faculty Council had approved the appointment of Miss Rae Chittick to act on the Internal Committee on Nursing Education as a representative of the A.A.R.N.

3. The increasing number of candidates writing the R.N. examinations has made necessary some changes in the administration of the examination. In April, 1953, the National League of Nursing Education State Board Test Pool papers will be tried on an experimental basis.

4. The disposition of resolutions approved at the 1951 annual meeting was reported, many of them to be discussed more fully by the specific sections concerned.

5. Many visits had been made during chapter and district meetings. In more distant areas by discussion the organization of new chapters had been stimulated. There are 12 chapters and 5 district associations at the present time.

A most comprehensive report of the Nursing Aids Committee was read by its chairman, Miss Ferguson, showing continued progress and much good work on the part of the committee. It is planning to interpret the role of nursing assistants through regional institutes for graduate nurses. In this way, those employing the assistants will be given a thorough understanding of their role and should be able to use their services to the best advantage.

The afternoon meeting was devoted to problems of civil defence, opening with Mr. Perrot's address on "Provincial Organization of Civil Defence." In his talk he stressed the necessity of thinking of civil defence as disaster defence—a form of insurance against disaster in whatever form it may occur.

Mrs. Van Dusen, nurse coordinator for Civil Defence, presented developments directly concerning the contribution being made by nurses. Goals were defined and a definite plan had been set up. Selected nurses had attended a four-day institute on the nursing aspects of A.B.C. Warfare under instructions of a national group. They, in turn, have taught other instructors who have

Front row (left to right): MRS. C. VAN DUSEN, Registrar; H. PENHALE, First Vice-President; FRANCES FERGUSON, President; E. BIETSCH, Second Vice-President; SISTER L. MONGRAIN, Councillor. *Second row (left to right):* J. MORRISON, Treasurer; JEAN CLARK, Past President; MRS. E. GARRATT, Private Duty Nursing Committee Chairman; M. FITZSIMMONS, Public Health Nursing Committee Chairman.

given to nursing groups in local communities a modified course of 12 hours. Included also was a report by Miss Mary Acland regarding the work of St. John Ambulance in civil defence.

Tuesday morning was arranged for the various special interest sessions. In the afternoon a "Survey of Alberta's Health" was presented in symposium form. This survey of the past and present health pattern, with recommendations for the future, was prepared by the Alberta Health Survey Committee for presentation to the government of Alberta. The objective of the survey was not only to serve as a basis for the distribution of the Federal Health Grants but to evaluate the present health facilities so that valid recommendations might be made regarding all health services. The symposium was introduced and capably summarized by Miss Isabel Reesor, the other participants being: Miss W. Day, Mrs. E. Michael, Miss L. Kremer, and Miss M. Deane-Freeman.

As a result of the recommendations, there has been expansion of existing rural health services by increasing the area of some units or incorporating smaller units into adjacent larger ones for more efficient administration. Of the 180 professional training grants awarded since 1948, 74 were requested by nurses.

Mr. G. Willis of the North American Life and Casualty Company spoke briefly to explain that the A.A.R.N. could not be included in their Group Insurance Plan as an insufficient number of members had applied for it.

A report by Miss E. Bietsch regarding the Structure Study was the first item Wednesday morning. A review of the history, purpose, and functioning of the Study was clearly presented and an outline given of the suggested changes arising from it. It was expected there would be further study of this report following the biennial meeting of the C.N.A.

The following are recommendations arising from the various special interest sessions:

1. That the minimum gross salary for registered nurses, full employment, first level, be $190-200; the current minimum salary for a head nurse be $205-215; the

minimum gross salary for matrons be $250 with semi-annual increases.

2. Fees for private duty nurses were raised to $9.00 for 8-hour duty in home or hospital, those for other types of service being adjusted accordingly.

3. That the A.A.R.N. bring to the attention of the Minister of the Department of National Employment Service, its disapproval of the appointment of a non-nurse as director of the Nurse Placement Bureau for Alberta, and the strong feeling of the association that this position can most effectively be filled by a professionally trained nurse.

In her closing remarks the president announced the appointment of Miss Lois Kremer as nurse coordinator for Civil Defence for Alberta.

CLARA VAN DUSEN
Registrar
Alberta Association of Registered Nurses

Book Reviews

The Care of the Ageing and Chronic Sick, by A. P. Thomson, M.C., M.D., C.R. Lowe, M.D., Thomas McKeown, Ph.D., M.D. 133 pages. The Macmillan Co. of Canada Ltd., 70 Bond St., Toronto 2. 1951. Price $1.45.

When the National Health Services in Britain began its study of the problems presented by the old, the destitute, and the chronically ill citizens, it was found that the great majority of these patients were accommodated in infirmaries which had evolved from the workhouses of an earlier generation. A detailed study, involving considerable research, was undertaken in 1948 to determine the extent of the problem posed by these classes of patients. It was feared that the very weight of numbers might swamp the administration of the hospitals under the new service. This book is a report on the findings of the investigators. Some of their conclusions are of interest and significance in Canada because we have a gnawing problem of providing care for the aged and infirm.

The survey revealed that no less than 60 per cent of the patients required neither frequent medical attention nor skilled nursing. More than half of the patients could be looked after in their own homes or in institutions other than hospitals where they could be washed, fed, and dressed. The dearth of the latter type of institutions—much less expensive to operate than general hospitals—was striking. Housing problems and a disinclination on the part of younger members of the family to provide necessary facilities for looking after the old folk were vital factors. Only a small proportion of the inmates of the infirmaries had a wedded mate living.

Dr. Thomson suggested that the problem of finding personnel to look after all those who did not require skilled nursing care might be solved by recruiting the staffs from the middle-aged and vigorous old age group. The administrative positions in such institutions might be made attractive enough to appeal to qualified nurses at or approaching retirement age. The maintenance of even a portion of these patients in their own homes requires the provision of some form of domiciliary nursing service.

The lack of interest in chronic sickness of elderly people is due largely to the absence of the dramatic appeal that is part of the provision of care for acute illness in the young. Complete recovery in the older group is rarely possible and the results often seem disproportionate to the effort required. Still these problems are with us and must be met.

Handbook of Diseases of the Blood, by A. Piney, M.D., M.R.C.P. 213 pages. J. B. Lippincott Co., Medical Arts Bldg., Montreal 25. 1951. Price $5.75.

Reviewed by Lottie Smith, Supervisor, General Hospital, Kingston, Ont.

This is a neatly set up, well written handbook on the pathology of the blood and the blood-forming organs, directed primarily to the general physician.

The author has divided the text into five separate sections. The first gives a detailed description of the clinical signs and symptoms

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A few comments from prominent nurses (names on request):

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of the diseases of the blood; the second covers the anemias; the third, overgrowths of hemopoietic tissue; the fourth and fifth, hemorrhagic diseases and symptomatic blood changes, respectively. The written material is interspaced with four attractive color plates and a few black and white photographs of the various conditions.

Dr. Piney emphasizes throughout the bedside approach to the problems of the blood disorders as opposed to the relegation of these conditions to the clinical pathologist. "The present book is an attempt to depict hematology as primarily a bedside subject, which is the province of the physician who, like his cardiological colleague, must be able to deal with the fundamental laboratory work himself."

Because of the emphasis placed on the bedside approach, there is adequate discussion of the more common entities but, unfortunately, the illustrations show almost solely the rareties.

Nurses will find this book helpful in its description of the common blood dyscrasias but will not receive as much help from the detailing of methods of testing and the significance of the results obtained from these tests.

This text would probably be most useful to nurses associated with the medical wards of a teaching hospital where there is a special interest in hematology. Also, it would be of value as a reference book on the pathology of the blood in the nursing school library.

Essentials of Pharmacology and Materia Medica for Nurses, by Albert J. Gilbert, M.D., and Selma Moody Brawner, R.N. 343 pages. McAinsh & Co. Ltd., 1251 Yonge St., Toronto 5. 3rd Ed. 1951. Price $4.25.

Reviewed by Sister Mary Doris, Pharmacy, St. Joseph's Hospital, Victoria.

This volume, as the name suggests, was published to provide the student nurse with an outline of the essentials and basic principles of pharmacology. It is not intended to be a complete and exhaustive study of the subject but rather a firm foundation on which to build more detailed knowledge. The manner of presentation is evidently designed to stimulate interest in further study. The text itself is written to fit a 30-hour teaching program.

The study of pharmacology is very closely associated with that of anatomy and physiology and a thorough grasp of these subjects is essential before drug actions and effects can be interpreted intelligently. It is impractical to speak of basal anesthetics, diuretics, cerebral stimulants or depressants, or other medications, unless the student has a mental picture of the anatomical position and functions of the organs affected by these preparations. A quick review of basic anatomy and physiology is nearly always necessary before any new system of drugs is introduced. Particularly is this true in modern nursing in which such an extensive course is covered in so short a time that details are often forgotten. Gilbert and Brawner have included such a review at the beginning of each chapter, providing the nurse with a brief refresher course in anatomy and physiology before branching into pharmacology—a very practical and profitable approach to a difficult subject. This feature also makes the book valuable as a ready reference on the wards, since from its pages needed information can be picked up quickly in its entirety.

The usual classifications, such as will be found in the majority of books on this subject, are adhered to in the text. However, particular emphasis is given to the newer drugs. The only difference here from other texts is that these drugs are included in the particular division to which they apply rather than classed together under the general title of New Drugs. For example: In discussing drugs acting on the autonomic nervous system, Priscoline Hydrochloride is mentioned as a sympathetic antagonist. From this statement and from its position in the general picture, certain actions can be anticipated immediately—e.g., it would dilate the blood vessels and cause a drop in blood pressure, etc. Sufficient interest is aroused by this association of ideas to leave a permanent impression on the mind. While it is appreciated that any recently published book would naturally contain a greater number of the new therapeutic agents, the method of presentation plays a very important part, either to stimulate interest in the mind of the reader or merely to be another tabulated system of names and doses quickly learned and as quickly forgotten, leaving little or no lasting impression.

The chapter on prescription reading is of considerable value. It would not need to be included in the 30-hour teaching program but it is an excellent method of acquainting student nurses with something that will form a large part of their professional day—the reading of doctors' written orders and, still more important, their prompt and precise execution. Many an embarrassing situation can be avoided by the nurse who is able to read and, in reading, understand the intention of the physician.

The book offers nothing new in the teaching of drugs and solutions. A short review in arithmetic is included and then the usual word formulae are resorted to. The method of memorizing certain formulae for specific types of problems is unsatisfactory for two reasons: first, the student relies entirely on memory with no effort to solve the problem from a mathematical approach; and, secondly, "memory is the faculty that forgets." Word formulae are always on the top of the list of things forgotten. This results in students doing amazing and impossible mathematical gymnastics on paper whereas a little careful thought on the subject would have shown their absurdity.

In appraising the volume as a whole, I would say that it is excellent. The language and phraseology are exact yet particularly easy to understand. It leaves the reader with a feeling of knowledge definitely acquired and a desire for more. For the student nurse, it is a valuable handbook; for the graduate, an excellent ready reference; and for the teacher, a highly satisfactory classroom text for the standard 30-hour course in pharmacology.

Anatomy and Physiology for Nurses, by W. Gordon Sears, M.D. 395 pages. The Macmillan Co. of Canada Ltd., 70 Bond St., Toronto 2. 2nd Ed. 1951. Price $1.90. *Reviewed by Yvonne L. Mogen, Science Instructor, General Hospital, Edmonton.*

Immeasurable value is gained in this book by the fact that the author is a former teacher and examiner of nurses. As stated in the preface, and stressed throughout the chapters, he has attached extreme importance to "the necessity of keeping the work as simple as possible but at the same time of maintaining the scientific and technical approach to the subject which the nurse will encounter in her work in a modern hospital."

The presentation of the material is both comprehensive and concise. It not only includes very pertinent illustrations of the practical applications of various anatomical and physiological facts but also introduces the

newer observations on blood grouping, the Rhesus factor, the electroencephalogram, and Cortisone. Another favorable factor is the inclusion of numerous, well defined diagrams which are easily interpreted by the reader. They would serve as excellent study guide material for the student.

The clarity and conciseness of the book are brought out in the use of well defined charts, point-form tabulations, and statements in bold and small type which stress adequately the more important phases of the subject. Because of this the book would be of excellent service for review purposes.

Ontario

The following are staff changes in the Ontario Public Health Nursing Service:

Appointments: *Mrs. Louise Park* (Hamilton Gen. Hosp. and University of Toronto general course and advanced course in administration and supervision) to the regional supervisory staff, formerly public health nursing supervisor with Leeds and Grenville health unit for past four years.

A new health unit has been established in the district of Thunder Bay with *Dorothy Adams* (Winnipeg Gen. Hosp.; U. of T. gen. course; McGill University admin. and supervision course), formerly with Neebing Township, as public health nursing supervisor. The following have been appointed to the staff *Ruth Baddeley* (St. Joseph's Hosp., Toronto, and U. of T. gen. course) and *Verna Bates* (Montreal Gen. Hosp. and U. of T. gen. course).

The city of Owen Sound has effected an amalgamation of the nursing services of the boards of health and education, resulting in the establishment of a generalized public health nursing service under the board of health with *Mildred Jarvis* (St. Catharines Gen. Hosp. and U. of T. gen. course), formerly with Northumberland and Durham health unit, as public health nursing supervisor. The staff includes: *Marjorie Cruickshank* (Gen. & Marine Hosp., Owen Sound, and U. of T. gen. course), formerly with Owen Sound board of education, *Olga Stewart* (Gen. & Marine Hosp., Owen Sound, and U. of T. gen. course), and *Greta Whiteley* (St. Catharines Gen. Hosp. and U. of T. gen. course).

Eleanor Earle (A. Barton Hepburn Hosp., Ogdensburg, N.Y., and U. of T. gen. course) from senior nurse to public health nursing

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supervisor with Leeds and Grenville health unit. The following have been appointed to the unit: *Marian Cuthbertson* (Ottawa Civic Hosp. and U. of T. gen. course), *Dorothea Flood* (St. Vincent de Paul Hosp., Brockville, and University of Western Ontario certificate course), *Lucille Miquelon* (Ottawa Civic Hosp. and U. of T. gen. course), and *Jean Sugg* (Royal Victoria Hosp., Barrie, and U. of T. gen. course).

Margaret Atkinson (Women's College Hosp., Toronto, and U. of T. gen. course and advanced course in admin. and supervision) from senior nurse to public health nursing supervisor with Stormont, Dundas and Glengarry health unit. The following have been appointed to this unit: *Martha Kryski* (University of Ottawa undergraduate and graduate courses), *Margaret Baillieul* (Gen. Hosp., Glace Bay, N.S., and U. of T. gen. course), and *Laurette Boudreault* (U. of O.).

Mrs. Jean Phillips (Victoria Hosp., London, and U. of T. gen. course and advanced course in admin. and supervision) and *Roberta Mathie* (St. Joseph's Hosp., Hamilton, and U.W.O. cert. course) as public health nursing supervisor and staff nurse respectively with Dufferin Co. health unit; *Heather McDonald* (U. of O. undergraduate and graduate courses and U. of T. advanced course in admin. and supervision) and *Elsie Uens* (Women's College Hosp., Toronto, and U. of T. gen. course) as public health nursing supervisor and staff nurse respectively with Muskoka district health unit, *Jean Falconer* (Kitchener-Waterloo Hosp., U.W.O. cert. course; U. of T. advanced course in admin. and supervision), formerly senior nurse with Wellington Co. health unit, and *Marion Laughren* (T.G.H. and U. of T. gen. course) as public health nursing supervisor and staff nurse respectively with Prince Edward Co. health unit.

Frances Fish (Hamilton Gen. Hosp. and U. of T. gen. course and advanced course in admin. and supervision), formerly public health nursing supervisor with Bruce Co. health unit, to similar position with Halton Co. health unit; *Mrs. Lyle Fauteux* (T.G.H. and U. of T. gen. course and advanced course in admin. and supervision) as public health nursing supervisor with Hamilton Dept. of Health; *Rita MacIsaac* (U. of O. undergraduate and graduate courses and U. of T. advanced course in admin. and supervision) as public health nursing supervisor, Ottawa board of health; *Margaret Turner* (H.G.H. and U.W.O. cert. course and U. of T. advanced course in admin. and supervision), formerly with Halton Co. health unit, and *Mary Buchanan* (Guelph Gen. Hosp. and U. of T. gen. course) as acting public health nursing

supervisor and staff nurse respectively with Peel Co. health unit.

Jane Minott (T.W.H. and U. of T. gen. course), formerly with Oshawa board of health, to newly established school health service in provisional County of Haliburton; *Isabel Petrie* (B.Sc.N., U. of T.), *Hazel Knox* (Ottawa Civic Hosp. and U. of T. gen. course), formerly with Leeds and Grenville health unit, *Anna Leslie* (Toronto East Gen. Hosp. and U. of T. gen. course), and *Helen (Black) Selman* (B.Sc.N., U. of T.) to East York-Leaside health unit; *Mae Haviland* (Victoria Hosp., London, and U.W.O. cert. course and U. of T. advanced course in admin. and supervision) as senior nurse, Oxford health unit; *Jean Hawkins* (B.N. Sc., Queen's University), *Edith Munroe* (Ottawa Civic Hosp. and U. of T. gen. course), and *Ethel Rutledge* (Kingston Gen. Hosp. and U. of T. gen. course) to Kingston board of health.

Gisèle Meloche (U. of O. undergraduate and graduate courses), *Françoise Vachon* (Ste. Justine Hosp., Montreal, and U. of O. cert. course), and *Berthe Vaillancourt* (U. of O.) to Prescott and Russell health unit; *Elsie Crawford* (Peterborough Civic Hosp. and U. of T. gen. course) and *Olive McKeachnie* (O.C.H. and U.W.O. cert. course) to Kenora-Keewatin-Dryden area health unit; *Jean Andrews* (St. Joseph's Hosp., Peterborough, and U. of O. cert. course) and *Jennie Stremecki* (Holy Cross Hosp., Calgary, and U. of T. gen. course) to St. Catharines-Lincoln health unit; *Mary Ankcorn* (Owen Sound Gen. & Marine Hosp. and U. of T. gen. course), *Christina MacLeod* (McKellar Gen. Hosp., Fort William, and U. of T. gen. course), and *Lucille Tracey* (St. Michael's Hosp., Toronto, and U. of T. gen. course) to Simcoe Co. health unit; *Marjorie Broadbent* (Public Gen. Hosp., Chatham, and U. of T. gen. course), *Jean Couture* (U. of O.), and *Thelma Smith* (Kingston Gen. Hosp. and U. T. gen. course) to Temiskaming health unit; *Evelyn Flaxman* (T.G.H. and U. of T. gen. course) and *Elizabeth Wilson* (T.E.G.H. and U. of T. gen. course) to Northumberland and Durham health unit.

Lillian Lawder (Hosp. for Sick Children, Toronto, and U. of T. gen. course), *Amy Keown* (Wellesley Hosp., Toronto, and U.W.O. cert. course), and *Ruth Paterson* (T.E.G.H. and U.W.O. cert. course) to Brant Co. health unit; *Ena Powell* (H.G.H. and U. of T. gen. course) and *Anna Stein* (Brantford

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Gen. Hosp. and U.W.O. cert. course) to Stratford board of health; *Frances Hamlin* (Women's College Hosp., Toronto, and U. of T. gen. course) and *Helen Pinzhoffer* (St. Michael's Hosp., Toronto, and U. of T. gen. course) to Welland and district health unit; *Anita Melvanin* (St. M.H., Toronto, and U. of T. gen. course) to Port Arthur board of health; *Dora Knell* (St. Mary's Hosp., Timmins, and U.W.O. cert. course) and *Denise Tremblay* (U. of O.) to Porcupine health unit. *Mildred Seifert* (Montreal Gen. Hosp. and McGill U. p.h.n. course) to Elgin-St. Thomas health unit; *Gloria Akiwenzie* (St. Mary's Hosp., Kitchener, and U.W.O. cert. course) to Bruce Co. health unit; *Mrs. Bessie Ballard* (T.E.G.H. and U. of T. gen. course) to Etobicoke Township Board of health; *Madeleine Carr* (M.G.H. and U. of T. gen. course) to Lennox and Addington health unit; *Josephine Hefferman* (St. M. H. Toronto, and U. of T. gen. course) and *Margaret Lessells* (Brantford Gen. Hosp. and U. of T. gen. course) to Oshawa board of health; *Violet Sam* (Brantford Gen. Hosp. and U. of T. gen. course) to Lambton health unit; *Elizabeth Schaefer* (St.M.H., Kitchener, and U. of T. gen. course) to Wellington Co. health unit; *Wilhelmina Ahern* (O.G.H. and McGill U. p.h.n. course) to Sault Ste. Marie board of education; *Susan Scales* (Guelph Gen. Hosp. and U.W.O. cert. course), formerly with Stratford board of health, to Perth Co. school health service. *Lenna Richardson* (Hamilton Gen. Hosp. and University of Western Ontario certificate course) as senior nurse, Wellington Co. health unit; *Françoise Brind'Amour* (University of Ottawa undergraduate and graduate courses) and *Betty Elliott* (Ottawa Civic Hosp. and University of Toronto general course) to Ottawa board of health; *Juliette Fortin* (St. Joseph's Hosp., Sudbury; U.W.O. cert. course; McGill University advanced course in administration and supervision in public health nursing) and *Winifred Jarvie* (Victoria Hosp., London, and U.W.O. cert. course) to Windsor board of health; *Muriel Morgan* (H.G.H. and U. of T. gen. course) to Oxford health unit; *Mary Pickens* (Civic Hosp., Peterborough, and U.W.O. cert. course) to Belleville board of health; *Lena Riddell* (Montreal Gen. Hosp. and U.W.O. cert. course) to Guelph board of health; *Mona Sharpe* (Women's College Hosp., Toronto, and U. of T. gen. course), formerly with Northumberland and Durham health unit, and *Jean (Taylor) Eagle* (Vancouver Gen. Hosp. and University of British Columbia public health nursing course), formerly with Hamilton Department of Health, to Etobicoke Township board of health.

An exchange of public health nurses is being carried out for a period of one year between the Metropolitan Health Committee, Vancouver, and the Kitchener board of health. *Kathleen Cameron* of Vancouver has joined the Kitchener staff and *Jean McEwan* of Kitchener is with the Metropolitan Health Committee.

Resignations: *Evalyn Greene* from Oshawa board of health to pursue post-graduate study at McGill University; *Elizabeth (Kerswill) Westcott* and *Barbara Ross* from Etobicoke Township. The following have resigned from the Stormont, Dundas and Glengarry health unit: *Rhea Kavanagh* as public health nursing supervisor, *Kathleen Redgate* to pursue post-graduate study, and *Grace*

Daigneault. *Miriam MacDonald* as public health nursing supervisor, Prince Edward Co. health unit; *Mrs. Helen Littleton* as public health nursing supervisor with Peel Co. health unit to pursue post-graduate study in administration and supervision in public health nursing; *Harriette Wilson* from Kitchener board of health; *Mildred (Laughlen) Fox* from Belleville board of health; *Lyla Groat* from Owen Sound board of health; *Beryl Williams* from Oshawa board of health; *Eva Ruddy* from Brant Co. health unit; *Laura Pletch* from Welland and district health unit; *Dorothy Pickering* from Leeds and Grenville health unit; *Beatrice Blair* from Lennox and Addington health unit; *Fern McPhee* from Bruce Co. health unit; *Norine (Gardiner) Crompton* from East York-Leaside health unit; *Mary Heard* from Elgin-St. Thomas health unit.

The following nurses have enrolled in the advanced course in administration and supervision at the University of Toronto School of Nursing: *Kathleen Abbott* from North York board of health; *Ruth Aiken* from Porcupine health unit; *Evelyn Dougher* from Hamilton Department of Health.

Victorian Order of Nurses

The following are the staff changes in the Victorian Order of Nurses for Canada:

Appointments — Amherst, N.S.: *Nathalie Durning* (Victoria Gen. Hosp., Halifax). Galt, Ont.: *Mary Mitchell* (Winnipeg Gen. Hosp.). Halifax: *Sophia Koziol* (Hamilton Gen. Hosp., Ont., and McGill University). Montreal: *Carolyn Brunning* (Hartford Hosp., Conn.), *Mrs. Gwendolyn Hermann* and *Lorraine McGregor* (Royal Victoria Hosp., Montreal, and McGill U.), *Joan McF. Livingston* (St. Bartholomew's Hosp., London, Eng.), *Claire (Harris) Smith* (Jewish Hosp., Brooklyn, N.Y.). Prince Albert, Sask.: *Janet Williams* (Vancouver Gen. Hosp. and University of British Columbia).

Transfers—*Isobel Angus* from Vancouver to Elphinstone, B.C., as nurse in charge; *Margaret Arnett* from Surrey, B.C., to North Vancouver; *Anne Baker* from Elphinstone to Trail, B.C., as nurse in charge; *Mary De Giacomo* from Thorold, Ont., to Regina, Sask., as nurse in charge; *Lois Leeson* from Smiths Falls, Ont., to Dundas, Ont., as nurse in charge; *Jeannine Nobert* from Rouyn-Noranda, Que., to Edmundston, N.B., as nurse in charge.

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Resignations— Dartmouth, N.S.: *Anne Adams.* Edmonton: *Josephine Burroughs.* Halifax: *Frances Willis.* Kingston *Margaret Donevan, Muriel Read.* Montreal: *Annette* and *Jacqueline Gregoire.* New Glasgow, N.S.: *Mrs. Winnifred Forbes.* Owen Sound, Ont.: *Jane (Dunfield) Ouellette* as nurse in charge. Prince Albert, Sask.: *Mrs. Margaret McConechy.* Ste. Anne de Bellevue, Que.: *Pierrette Daoust* as nurse in charge. Sarnia, Ont.: *Edna May Stoddart.* Sherbrooke, Que.: *Germaine D'Allaire.* Trail: *Grace Pettifor* as nurse in charge. Vancouver: *Anne Steem.* Windsor, N.S.: *Jean Adams.* Windsor, Ont.: *Helen Hill, Mrs. Mary Porter.*

Alberta

The following are news items from the Alberta Division of Public Health Nursing:

There are many new health units being organized this year and in some areas it means a new service taking the place of the old. A full-time unit has been formed to include the city of Medicine Hat and surrounding district. This will replace the former well baby clinic served in that city by *M. Hagerman* and recently by *Marion Story,* who is now senior nurse. It will include the municipal nursing service at Bow Island and the one-nurse health unit at Brooks. The Hilda Municipal Nursing Service will carry on as usual.

The one-nurse health unit at Strathmore is now included in the East Calgary health unit, named the Bow Valley health unit, with *Ethel Jones* a member of this staff.

The well baby clinic at Vegreville is now absorbed into a health unit. *Mary Black,* who has served on the staff of the clinic for 26 years, has joined the new unit.

Mrs. Katherine Cole, who for many years was on the staff as district nurse, went up to Hay River, N.W.T., just beyond the Alberta boundary, last May, to organize a district nursing service for the local community. It is a project sponsored by the local citizens as they are many hundreds of miles from doctors or hospitals.

Mrs. Barbara Eben, who wrote the "Obstetric Manual for District Nurses," will teach the advanced practical obstetrical course at the University of Alberta this fall.

Lois Hammett of Hines Creek and *Ingor Sorenson* of Grassland are on leave of absence to take the public health course at the university. *Marguerite Ries* is enrolled in the advanced obstetrical course.

Mona Wilson, public health nursing director for Prince Edward Island, spent a short time in Edmonton visiting the various health services.

Margaret Smith is stationed at New Brigden, *Valerie (Wheeler) Wiens* resigning from this district. *Edna F. Drake* is at Sunnynook.

Evangeline Boyarchuk is at Tulliby Lake, replacing *Mrs. Mabel Grant* who is now matron of a small Saskatchewan hospital. *Lois Badgley* is at Hines Creek. *Esther (Dearing) Anderson* is carrying on the service at Dixonville. *Edith Gavin* replaced *Mrs. D. (Mynard) Walker* at Fawcett. *Mina Pool* has returned to Athabasca health unit after taking the University of Alberta public health course. The reorganization of this unit is under way, according to the new Health Unit Act. *Jean Brickman,* formerly with Athabasca health unit, is on the staff of the Aberhart Memorial Hospital. *Mrs. V. Fadeeff* replaces *Mrs. Sabin* at Winfield. *Sarah MacIntyre* is at Kinuso replacing *Carol Gaunt* who resigned. *Phyllis (Warner) O'Neill* is continuing with her duties at Peers. *Madeline Bonneville* has resigned from Spirit River health unit.

British Columbia

The following are staff changes in the British Columbia Division of Public Health Nursing:

Appointments—*Isabel Anderson* to Greenwood, West Kootenay health unit, after leave of absence to attend the McGill University public health nursing course; *Marjorie Baunerman* (Vancouver Gen. Hosp.) to Cranbrook, East Kootenay health unit; *Maxine Bolton* to Oliver, South Okanagan health unit, after leave of absence to attend the University of British Columbia public health nursing course; *Mae Conn* to Enderby, North Okanagan health unit, after leave of absence to attend U.B.C.; *Marguerite Cusson* (University of Alberta School of Nursing and B.S.N., U.B.C.) to Agassiz, North Fraser Valley health unit; *Audrey Damgaard* to Kamloops, Central Interior health unit, after leave of absence to take the p.h.n. course at U.B.C.; *Jessica Field* (Royal Alexandra Hosp., Edmonton, and U.B.C. p.h.n. course) to Nanaimo, Central Vancouver Is. health unit; *Hazel Fulmore* to Ladysmith, Central Vancouver Is. health unit, after completing the U.B.C. p.h.n. course.

Eileen Hassett (Royal Columbian Hosp., New Westminster) to Prince George, Cariboo health unit; *Aldred Ker* to Ashcroft, Central Interior health unit, after leave of absence to take the U.B.C. p.h.n. course; *Dorothy Kergin* (V.G.H. and B.S.N., U.B.C.) to Princeton, South Okanagan health unit; *Jean MacAllister* (V.G.H. and U.B.C. certificate course) to Trail, West Kootenay health unit; *Catherine MacKinnon* (Royal Victoria Hosp., Montreal, and B.N., McGill University) to Kimberley, East Kootenay health unit; *Lorene Monahan* (Gen. & Marine Hosp., Owen Sound, Ont., and B.A. and p.h.n. course, University of Toronto) and *Barbara Vidal* (Holy Cross Hosp., Calgary, and McGill U. p.h.n. course) to Chilliwack, Upper Fraser Valley health unit; *Dorothy Morris* (V.G.H. and B.A., B.A.Sc., U.B.C.) and *Phyllis Payton* (V.G.H.

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Write for information & applications to:

Supt. of Nurses in respective Units or to Personnel Assistant, Division of T.B. Control, 2647 Willow St., Vancouver 9, B.C.

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Salary: $233 rising to $276 per mo. Promotional opportunities available for *Public Health Nurses, Grade 2* — $250 rising to $303 per mo.

Qualifications: Candidates must be eligible for registration in British Columbia and have completed a University degree or certificate course in Public Health Nursing. (Successful candidates may be required to serve in any part of the Province; cars are provided.) Further information may be obtained from the *Director, Public Health Nursing, Dept. of Health & Welfare, Parliament Bldgs., Victoria.*

● Candidates must be British subjects, under 40 years of age, except in the case of ex-service women who are given preference. Application Forms obtainable from all *Government Agencies, the Civil Service Commission, Weiler Bldg., Victoria,* or *636 Burrard St., Vancouver 1,* to be completed & returned to the

Chairman, Victoria.

and U.B.C. p.h.n. cert. course) to Cloverdale, Boundary health unit; *Ada O'Brien* to Port Alberni, Central Vancouver Is. health unit, after leave of absence to take the McGill U. p.h.n. course; *Phyllis Piddington* (Royal Jubilee Hosp., Victoria) to Matsqi-Sumas-Abbotsford public health service; *Betty Pullen,* having completed the B.S.N. course at U.B.C., and *Paula Schwoerer* (St. Paul's Hosp., Vancouver, and U.B.C. p.h.n. course) to Duncan, Central Vancouver Is. health unit; *Catherine Stevens* (St. Mary's Hosp., Timmins, Ont., and U. of T. p.h.n. course) to Smithers, Skeena health unit; *Ruth Stevens* (V.G.H. and B.S.N., U.B.C.) to Saanich and South Vancouver Is. health unit.

Transfers— *Alice Beattie* from West Kootenay health unit as supervising nurse to Kelowna, South Okanagan health unit, as supervisor; *Helen Byrt* from Enderby, North Okanagan health unit to Fernie, East Kootenay health unit; *Marjorie Craik* from Chilliwack, Upper Fraser Valley health unit to Fraser Canyon district; *Doris Gifford* from Cranbrook, East Kootenay health unit to Vanderhoof, Cariboo health unit; *Betty Herman* from Agassiz, Upper Fraser Valley health unit to Division of V.D. Control, Vancouver; *Nan Kennedy* to be senior nurse with Boundary health unit; *Elizabeth Layton* from Vanderhoof, Cariboo health unit to Saltspring area, Saanich and South Vancouver Is. health unit; *Mary McKinlay* from Cariboo health unit to be senior nurse at Chilliwack, Upper Fraser Valley health unit; *Beverley McNair* from Ashcroft Central Interior health unit to Lake Cowichan, Central Vancouver Is. health unit; *Kerstin Nelson* from Matsqui-Sumas-Abbotsford district to Creston, East Kootenay health unit; *Dorothy Neuman* from Greenwood, West Kootenay health unit to Coquitlam area, Simon Fraser health unit.

Janet (Maclennan) Rodgers from South Okanagan health unit to Central Vancouver Is. health unit; *Doris Vosburgh* from Fernie, East Kootenay health unit to be senior nurse with Cariboo health unit; *Mary Watson* from Prince George, Cariboo health unit to Lake Cowichan, Central Vancouver Is. health unit; *Hazel Whittington* from Ladysmith, Central Vancouver Is. health unit to Trail, West Kootenay health unit; *Joyce (Harrington) Young* from Port Alberni, Central Vancouver Is. health unit to Langford district, Saanich and South Vancouver Is. health unit.

Leave of Absence— To take the public health nursing course at U.B.C.: *Eleanor Bradshaw* from Peace River health unit; *Betty Dronsfield* from North Okanagan health unit; *Beryl Lucas* from Skeena health unit; *Beatrice MacKinnon* from Upper Is. health unit; *Elizabeth Ferrie, Margaret French, Clara Lysakowski, Alice Cannon* to take the p.h.n. course, Dalhousie University, Halifax; *Mary Kartner* from Boundary health unit to take the p.h.n. course at McGill University; *Janet Pallister* to take the course in supervision and administration in p.h.n. at McGill U.

Resignations— *Irene (Rae) Berryman* from Peace River health unit; *Jean Ciceri* to teach

at St. Joseph's School of Nursing, Victoria, *Dorothy Deeble* to go to Toronto, *Christine Humble*, and *Isla Tuck*—all from Saanich and South Vancouver Is. health unit; *Anna (Spence) Donaldson* from Boundary health unit; *Edith Fowler, Ethel MacPherson, Mary McNair* to be married, *Gwen (Farquharson) Mitchell* to live in Alberta, and *Ada Stadnyk* —all from Central Vancouver Is. health unit; *Shirley (Scanlan) Humphreys* and *Joan Madden* from Central Interior health unit; *Susie Jones* from Gibson's public health service to go to California; *Shirley (Robinson) Leonard* from Nakusp public health service; *Eileen Lovett* from Coquitlam staff, Simon Fraser health unit; *Gwen (Oxley) McClelland* from Hope, Upper Fraser Valley health unit; *Rosemary (Steward) Pesut* from Princeton, South Okanagan health unit; *Lenna Richardson* and *Margene (Clark) Yuill* from Trail, West Kootenay health unit; *Mary Wade* from Haney, North Fraser Valley health unit.

News Notes

ALBERTA

DRUMHELLER

Della McQuarrie of Coleman has been appointed matron of the hospital here. She has recently completed a post-graduate course in hospital management and supervision at the New York Polyclinic Hospital. Prior to leaving for New York, Miss McQuarrie was on the staff of the Crow's Nest Pass Municipal Hospital.

BRITISH COLUMBIA

KELOWNA

A very successful dance was held in June by the Kelowna Chapter at the Aquatic Club, the net proceeds being $150.

VANCOUVER

St. Paul's Hospital

The Benevolent Group of the alumae association has had four more woollen blankets made from the old wool donated by members earlier this year. The annual bazaar is scheduled for November 19 at the nurses' residence.

Muriel Wilkinson has replaced A. Belecky as registrar for the private duty nurses of St. Paul's. Miss Belecky is now a member of the 3rd East staff in the hospital. The private duty nurses entertained Miss Belecky at a surprise party when a lovely handbag was presented to her.

Sr. Catherine De Bologne is first assistant

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For further information write to:

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For further information write to:

Supt. of Nurses, General Hospital, Winnipeg, Man.

general, Providence Maison Mère, Montreal. Sr. Teresina (M. J. Levasseur) is Mother Provincial at Lacombe Home, Midnapore, Alta. Sr. Anne of the Sacred Heart (pediatrics) has completed her studies at Seattle University. S. (Towlan) Bates is on duty with the 3rd North staff, after several years' residence in Victoria. P. Hunter is employed in Dr. F. Word's office. T. Cahill and N. Allen are nursing at Tillamook, Oregon. B. Renshaw and A. Ackerman are in Kemano, B.C. B. Parlow plans to nurse in England. On duty at the Herrick Hospital, Berkeley, Calif., are: B. Pollock, L. Kirkland, J. Murray, M. Christensen. K. Koop is doing private nursing in Winnipeg. V. Shopland is at the Queen Alexandra Solarium for Crippled Children, Cobble Hill, V.I.

VICTORIA

An effort has been made during the past few months to bind the private duty nurses of this city more closely together into a group, that they may have a voice in chapter affairs and so be more aware of the comfort and strength of the Registered Nurses' Association of which they are a part. In an effort to interest more of the nurses, it was decided to hold meetings of the group every two months, in the form of dinner meetings held in the evening, each nurse paying for her own dinner. To date three of these meetings have been held and the turnout has been most gratifying. At the last meeting the clubroom of the Business and Professional Women's Club was rented and a caterer employed, thus keeping the charge to a minimum. The nurses are notified of the meetings through a telephone committee, thus eliminating the expense of sending out notices. It is hoped to hold meetings monthly in the fall, every second meeting to be held at noon so that the nurses who work the evening shift may attend. These nurses, in particular, feel somewhat out of touch as they rarely are able to attend either private duty or chapter meetings.

At the instigation of the private duty group, a refresher course was sponsored by the Victoria Chapter in June. Seven lectures and demonstrations of two hours and longer were held. In some instances the nurses were so interested in the demonstrations that they stayed on asking questions long after the two hours were up. A fee was charged for this course to defray expenses of notices and to give the lecturers some monetary recompense for the time and energy spent preparing and giving the lectures. The class was limited to 50, with members of the private duty group being given the first opportunity to enrol. Other interested chapter members completed the class enrolment.

During the past few months, through the kindness of L. Woodrow, director of nurses, Royal Jubilee Hospital, two or three private duty nurses at a time were invited to the hospital for a week and, under the supervision of the assistant director of nurses, Miss Gass, were able to visit various floors where treat-

ments were being carried out with which they were not familiar or where new equipment was being used. The nurses who availed themselves of this opportunity felt they had learned much in a practical way that they could not have learned from lectures alone.

The Victoria Chapter is pleased to welcome Marion Lindeburgh to the city.

Royal Jubilee Hospital

Six members of the spring post-graduate class in operating room technique and management received their pins and certificates in July. They were: B. Ayliffe, B. Freeman, B. Kornelson, E. N. McCulloch, D. Richmond, J. W. Spencer. Five members of this class have joined the O.R. staff at the hospital and one has returned to Abbotsford.

C. Leask is now O.R. supervisor at the General Hospital, Penticton. M. Moncrieff of the O.R. staff and I. O'Brien of maternity have registered at McGill School for Graduate Nurses for the course in teaching and supervision. D. Chung has decided to specialize in eye surgery and has entered the Manhattan, Eye, Ear and Throat Hospital for studies. S. Dorothy Andrew is now superintendent of the Shriners' Hospital for Crippled Children, Portland, Oregon. Miss Andrew is a native of Virden, Man.

NEW BRUNSWICK

MONCTON

The members of the Nurses' Hospital Aid entertained the 1952 graduating class of the Moncton Hospital at a dinner and dance. The address of welcome was given by the president of the Aid, Mrs. J. Morrell. Grace was said by Mrs. Nash Smith. M. Bird, Mmes. Morrell and K. Mayhew participated in the various toasts. The pianist was Mrs. D. Barberry and Mrs. R. Miller rendered a solo. The guests were received by F. Breau, superintendent of nurses at the hospital, Mmes Morrell and K. Lamb.

The closing meeting of the Aid was held at the summer home of Mrs. M. Perry at Hopewell Cape where the members went by chartered bus. Mmes. H. Henderson, G. Allen, and K. Lamb assisted the hostess in the preparation of a delicious lobster buffet lunch. Mrs. Morrell conducted the business meeting that followed. Mrs. S. Sinclair, who had convened the dinner and dance for the 1952 class of Moncton Hospital, assisted by several members, gave her report.

NOVA SCOTIA

LUNENBURG

Mrs. Ella E. Lamont has been appointed superintendent of the Fishermen's Memorial Hospital. She has served on the staffs of the Toronto East General Hospital, City Hospital, Sydney, General Hospital, Glace Bay, and General Hospital, New Waterford.

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Director of Nursing Service,
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New York City 21, N.Y.

TRURO

Appointment of Mrs. Sarah MacCarthy as superintendent of Colchester County Hospital has been announced. She succeeds Mrs. G. Bethel. Mrs. MacCarthy has been on the staff of the hospital for six years, serving as assistant superintendent for the last three. She is a graduate of Melrose (Mass.) General Hospital and came to Truro from the Dawson Memorial Hospital, Bridgewater, N.S.

ONTARIO

DISTRICT 1

CHATHAM

The Kent County Board of Health recently staged a dinner at Glen Gordon Manor to honor Phyllis Thompson, supervisor of nurses with the unit, prior to her departure to join WHO. Miss Thompson joined the unit on June 3, 1947, three months after it had started to function. Officials praised the part she had played during the past five years in organizing the nurses' territories and the various clinics throughout the county. On behalf of the Board, Miss Thompson was presented with a pen, pencil and thermometer set. Staff nurses gave her a training case, presented by Ethel Mason.

DISTRICT 3

MOUNT FOREST

Mrs. J. Benny is now matron at the Louise Marshall Hospital. Mrs. Benny, who began her nursing career in Kingston, was at one time matron at Fergus Hospital.

DISTRICT 5

TORONTO

General Hospital

A graduate of T.G.H. and the University of Toronto School of Nursing, Minnie I. Mackay has taken up her appointment as nursing arts instructor with the WHO nursing education project in Taipeh, Formosa. Miss Mackay at one time served on the teaching staff of her home school.

Irene Moore, a T.G.H. graduate, and a native of Thamesville, Ont., has sailed from Vancouver for Hong Kong where she will remain for five years. Miss Moore, as matron of the leper colony there, will have the responsibility of the organization of the colony situated on Hay Ling Chau Island which has contact with Hong Kong by its own motor launch. The appointment was made by the Woman's Missionary Society of the United Church as a result of an invitation from the Mission to Lepers Auxiliary in Hong Kong.

In July, 1951, the Hong Kong Government gave approval to the establishment of the Leprosarium on Hay Ling Chau Island where there are 100 patients at present and will have accommodation for 200 more in 1953. All work in preparation for building activities was carried out largely by the patients themselves. Miss Moore first went to China in 1938, working at the Canton Hospital until Pearl Harbor in 1941. After a period of internment at Canton, she was repatriated from Shanghai in 1942. The next few years she worked in Canadian mission hospitals at Battle River, Alta., and Hearst, Ont. Returning to Kongmoon, China, in 1946 she resumed hospital work there until again disturbed conditions resulted in her return to Canada in 1949.

On leave of absence for the last two years, Miss Moore has worked as clinical instructor at the Oshawa General Hospital. Having a knowledge of the Cantonese language, she has recently taken the advanced administration course at the University of Toronto School of Nursing.

St. Michael's Hospital

The first event of the Diamond Jubilee year, happening on July 2, 1952, exactly the 60th anniversary of the founding of St. Michael's Hospital, was the formal opening of the new nurses' residence at Shuter and Bond Streets, opposite the cathedral. Cardinal McGuigan blessed and dedicated the new building and presented a golden key to Premier Frost who officially opened the residence and was guest speaker.

The new seven-storey building, of red brick and stone, has terrazzo floors and pastel painted walls, along with window drapes, floor rugs, and modernistic upholstered furniture of durable type. The residence is equipped with every modern convenience for teaching and living.

At the June meeting of the alumnae association it was decided to make a gift of $500 to the hospital in honor of its Diamond Jubilee. Mrs. K. Gies gave her report as delegate to the C.N.A. convention in Quebec City. It was announced that L. McGurk would assume editorship of *The News*. A. Johnston was the winner of the door prize.

Reunions were held of the classes of 1927 and 1932. St. Michael's nurses in Sudbury also had a get-together.

His Holiness Pope Pius XII has been pleased to confer the medal *Bene Merenti* on two nurses at Sunnybrook Military Hospital, Toronto—Constance McCarthy and Julia Montgomery. The decoration is awarded in recognition of the devoted service they have given to the patients placed under their charge at Sunnybrook Hospital and in former years at Christie St. Military Hospital.

Betty Hornell is with the American Red Cross in Pittsburg, Pa. Lulu Marrin retires from the staff of the Henry Ford Hospital, Detroit, after 25 years' service. R. Cuddihey has accepted a position on the staff of King Edward VII Memorial Hospital, Bermuda. A. Creed is with the Windsor Receiving Hospital. J. Blaver is on the O.R. staff at Oakville-Trafalgar Memorial Hospital. G. Guilniette is with Grace Hospital, Richmond, Va.

Western Hospital

A T.W.H. graduate, Margaret Gordon, has been appointed superintendent of the Huntsville District Memorial Hospital, Ont. Born in India, she has lived in St. Thomas. Miss Gordon has had extensive experience in executive work and in active management of nursing services in several large hospitals in Ontario. Miss Clark, who has been acting superintendent, is first assistant.

DISTRICT 7

KINGSTON

Flying Officer Frances Fardella, a Hotel-Dieu graduate, is taking a special flight nurses' course in Alabama as part of her R.C.A.F. training. The special course is being given at the U.S. Air Force School of Aviation Medicine at Gunter Air Force Base in

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GRADE 2—$2,580 - $2,930

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Application forms, available at your nearest Civil Service Commission Office, National Employment Office and Post Office, *should be forwarded to the* CIVIL SERVICE COMMISSION, OTTAWA.

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General Hospital, Regina.

• *Salary:* $193 - 232 per month, including Cost of Living Bonus.

Registration as a nurse in the Province of Sask. plus experience or an affiliation in Psychiatric Nursing.

Apply to:
Public Service Commission,
328 Legislative Bldg., Regina, Sask.

Montgomery. It consists of six weeks' instruction and was instituted by the U.S.A.F. to qualify registered nurses in the basic sciences and special techniques necessary for the safe and efficient transportation of patients by air. The course is given to R.C.A.F. nursing sisters in order to render more understanding and efficient service in air evacuation at any time but especially in emergency. Upon successful completion of this course, F/O Fardella will receive three months' practical training in the Pacific theatre where she will be able to apply the lessons learned.

DISTRICT 9

SUDBURY

Flying Officer Mary Kennedy, a graduate of St. Joseph's Hospital, is taking a special flight nurses' courses in Alabama as part of her R.C.A.F. training. Joining the service at Montreal, she was stationed at Rockcliffe, being posted later to the Maritime Group Headquarters of the R.C.A.F. Prior to joining the air force, F/O Kennedy was with the D.V.A. in Vancouver and Montreal. During the last war, she served as a nursing sister.

QUEBEC

MONTREAL

Royal Victoria Hospital

After 24 years service, Annie Morris has resigned from the nurses' home staff to be married. She will be greatly missed by the nurses and other associates. Prior to her departure, several teas and presentations were held to express the good wishes of the hospital staff.

Margaret Street has resigned as secretary-registrar of the A.N.P.Q. to assume new duties with the University of British Columbia School of Nursing. Alma Foulkes is on the staff of the Cohama County Hospital, Clarksdale. Miss Margaret Baker is with the Mayo Hospital, Yukon.

Recent visitors have included: N/S S. Sterns, now Sister-in-Charge at Camp Borden, K. Gibson, E. Hall, R. McCoy, and G. Hopkins.

SWEETSBURG

Brome-Missisquoi-Perkins Hospital

The superintendent, Mrs. E. M. Wright, and staff entertained at an informal coffee party in honor of Winnifred King. Miss King has resigned as assistant superintendent to take a position with the Richmond-Drummondville Protestant School Board.

SASKATCHEWAN

SASKATOON

St. Paul's Hospital

Anna Cole is welcomed to the School of Nursing as health nurse. M. Dolan, intravenous nurse, has arrived from St. Michael's Hospital, Toronto. G. Johnston is in Cleveland, Ohio, taking a course in ward administration and teaching in surgical nursing at Western Reserve University, under the auspices of the W. K. Kellogg Foundation.

Effective reducing medication without too strict dietary control.

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Each s.c. tablet contains:

d-Amphetamine sulfate	3 mg.	Ovarian ext.	50 mg.
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Positions Vacant

Advertising Rates—$5.00 for 3 lines or less; $1.00 for each additional line.

Administration Asst. in Nursing. Beginning salary: $14 per day. Apply Director of Nurses, St. Joseph Hospital, Mt. Clemens, Michigan.

Registered Nurses for General Duty at Lyndhurst Lodge, Canadian Paraplegic Ass'n Rehabilitation Centre. Annual salary: $2,100 with yearly increases. 8-hr. day, 44-hr. wk. 3 wks. annual leave. 8 statutory holidays. Cumulative sick leave up to 30 days. Apply Dr. A. T. Jousse, 153 Lyndhurst Ave., Toronto 10, Ont.

Registered Nurses for General Duty. 35-bed active General Hospital, 50 miles from Toronto. Gross salary: $178 per mo. Apply Supt., Lord Dufferin Hospital, Orangeville, Ont.

General Duty Nurses for 500-bed Teaching Hospital with well planned rotation schedule. Salary: $210 per mo. gross plus annual increments for 4 yrs. B.C. registration required. Apply Director of Nursing, Royal Jubilee Hospital, Victoria, B.C.

General Duty Graduate Nurses for 60-bed General Hospital, situated 150 miles northeast of Vancouver on B.C. coast. Salary $222 per mo. less $25 for complete maintenance & laundering of uniforms. 4 wks. holiday with pay plus 10 statutory holidys. Transportation advanced if desired. Apply Matron, St. George's Hospital, Alert Bay, B.C.

Matron for new 17-bed Municipal Hospital. Easy access to Calgary & Edmonton. Pleasant working conditions. 1 mo. vacation with pay after 1 yr. of service. All statutory holidays. Sick leave time paid for if not used. Transportation refunded after 6 mos. service. Minimum salary: $195 per mo. less $20 for full maintenance. Splendid opportunity for nurse to gain administrative experience leading to better position. One **General Duty Nurse** can be used if two girls wish to travel together. Apply Sec.-Treas., Municipal Hospital, Elnora, Alta.

Hospital Supt.—Registered Nurse with hospital administration experience for 50-bed hospital with Training School. Full maintenance, vacation with pay & sick leave. Apply Chairman, Board of Trustees, Carleton Memorial Hospital, Woodstock, N.B.

Supt. of Nurses, Asst. Supt. of Nurses for 177-bed hospital. State salary expected. **Nursing Arts Instructor.** Salary: $220 gross. **Science Instructor.** Salary: $220 gross. **Head Nurse** for Private Wing—27 beds. Salary: $215 gross. **General Duty Nurses** for obstetrical, medical & surgical floors. Salary: $180-195 gross, depending on experience. 44-hr. wk. 2½ days holidays per mo. Half day on statutory holidays. 1½ days sick time per mo. cumulative to 30 days. Charge of $30 per mo. for board & room. Apply Mrs. M. Alexander, Acting Supt. of Nurses, General Hospital, Medicine Hat, Alta.

Night Supervisor, General Duty Nurses, Registered & Grace Maternity Graduates, Laboratory Technician. Apply, stating experience, Supt., Queens General Hospital, Liverpool, N.S.

General Staff Nurses will find real opportunity to realize their ideals in our 337-bed Teaching Hospital with University affiliation. Community offers unlimited choice of cultural & recreational facilities. 40-hr. wk. 3 wks. vacation. Paid sick leave. Rotating shift $1.30-1.40 per hr. Differential of 10 cts. per hr. for evening & night shifts. Apply Director of Nurses, Evanston Hospital, 2650 Ridge Ave., Evanston, Illinois.

General Staff Nurses for newly constructed hospital. Starting salary: $175 per mo. plus $10 differential for afternoon duty. Additional pay for post-graduate study & operating room technique & obstetrics. Good personnel policies. Apply Director of Nurses, General Hospital, Guelph, Ont.

General Staff Nurses for 600-bed University Hospital. Openings in all services. Personnel policies meet approved minimum standards of North Carolina State Nurses' Ass'n. Salary: $160 per mo. with complete maintenance ($220 without maintenance). $20 additional for permanent evenings & nights. $120 annual increment for satisfactory service. 44-hr. wk. 24 days vacation the 1st yr.; 30 days per yr. thereafter. Ill time allowance same as vacation. 6 holidays per yr. Exceptional opportunity for furthering education in Duke University. Write Director of Nursing Service, Duke University Hospital, Durham, North Carolina.

Registered Nurses for General Duty for small General Hospital. Salary: $140 per mo. with full maintenance. 6-day wk. 8-hr. duty, rotating shifts, 3 increments of $5.00 per mo. at 6-mo. intervals. Blue Cross paid. 10 days sick leave per yr. 6 statutory holidays. 28 days holiday. Apply Lady Supt., Barrie Memorial Hospital, Ormstown, Que.

General Duty Nurses for 60-bed hospital. Salary: $150 per mo. with 3 annual increments of $5.00. 48-hr. wk. Straight 8-hr. duty. $5.00 extra for evening & night duties. Full maintenance. 4 wks. vacation at end of 1 yr. service plus 8 statutory holidays. Apply Alexandra Marine & General Hospital, Goderich, Ont.

Graduate Nurses (2) for General Duty for immediate future. Starting salary: $200 with annual increments of $5.00 per mo. Full maintenance $40. Statutory holidays paid. 28 days vacation after 1 yr. service. Usual sick leave. Apply Miss A. Naomi Pow, Supt. of Nurses, Slocan Community Hospital, New Denver, B.C.

Registered Nurses: General Duty (3) $260 per mo. **Operating Room Scrub Nurse (2)** $270 per mo. Annual increase of $10 per mo. 8-hr. day, 40-hr. wk. Paid vacation — 2 wks. after 1st yr., 3 wks. after 3 yrs., 1 mo. after 5 yrs.; sick leave cumulative to 30 days. Quarters in nurses' home available at $20 per mo. Train fare refunded after 1st yr. of employment. Hospital is 155-bed General Hospital located in Fresno, California, in the heart of San Joaquin Valley, convenient to San Francisco, Los Angeles, Pacific Ocean beaches & many national parks. Several Canadian nurses are presently employed in this hospital as well as other hospitals in vicinity. Write for application form & visa information to C. H. Linville, Administrator, Community Hospital, 1234 "S" St., Fresno 1, California.

Graduate Nurses for General Staff Duty in 350-bed Tuberculosis Hospital. For further information apply Director of Nursing, Royal Edward Laurentian Hospital, Ste. Agathe des Monts, Que.

Graduate Nurses for General Duty. 48-hr. wk., 7 statutory holidays, 3 wks. vacation after 1 yr. service, 2 wks. sick leave per yr. Excellent train & bus service to Ottawa. Apply Supt. Arnprior & District Memorial Hospital, Arnprior, Ont.

General Duty Nurses immediately for Trail-Tadanac Hospital, Trail, B.C. Personnel practices as outlined by Reg. Nurses' Ass'n. of B.C. Apply Director of Nursing.

Nursing Arts Instructor & Asst. Supervisor for Operating Room for 450-bed General Hospital with 150 students. Apply Director of Nursing, General Hospital, Saint John, N.B.

VICTORIAN ORDER OF NURSES FOR CANADA

has Staff and Supervisory positions in various parts of Canada.

Personnel Practices Provide:

- Opportunity for promotion.
- Transportation while on duty.
- Vacation with pay.
- Retirement annuity benefits.

For further information write to:

Chief Superintendent,
Victorian Order of Nurses for Canada,
193 Sparks Street,
Ottawa 4, Ont.

General Duty Nurses for 430-bed hospital. 44-hr. wk. 11 statutory holidays. Salary: $215-253. Credit for past experience. Annual increments. Cumulative sick leave. 28 days annual vacation. Apply Director of Nursing, Royal Columbian Hospital, New Westminster, B.C.

Registered Nurses for General Staff in 21-bed hospital. Salary: $155 per mo. Room, board & uniform laundry provided. Rotating shifts. 48-hr. wk. Blue Cross Plan. 3 wks. holiday after 1 yr. service. Apply Supt. of Nurses, General Hospital, Espanola, Ont.

Registered Nurses (2) & Matron for hospital with 27 set up beds. Salaries: $160 & $200 per mo. plus full maintenance. 1 mo. holiday & usual sick leave. Hospital located in thriving town with good train & bus service. Apply Sec.-Mgr., Porcupine-Carragana Union Hospital, Porcupine Plain, Sask.

Registered Nurses for St. Joseph Hospital, Mt. Clemens, Michigan, 25 miles north of Detroit, near Selfridge Air Force Base. Optional 40- or 44-hr. wk. **Staff Nurses**: $12 day duty; $13 afternoon or night duty. State Standards. Apply Director of Nursing Service.

Graduate Nurses for completely modern West Coast hospital. Salary: $210 per mo. less $40 for board, residence, laundry. $10 annual increments. Special bonus of $10 per mo. for night duty. 1 mo. vacation with full salary after 1 yr. service. 1½ days sick leave per mo. cumulative to 36 days. Transportation allowance not exceeding $60 refunded after 1st yr. Also **Evening Supervisor** from 4:00 till midnight. Salary commences at $225. Working conditions & perquisites same as nurses. Apply, stating experience, Miss E. L. Clement, Supt. of Nurses, General Hospital, Prince Rupert, B.C.

General Duty Staff Nurses for 515-bed General Hospital. Beginning salary: $230 per mo. with advancement to $250. $20 additional for evenings & nights. 40-hr. wk. Hospital & school of nursing fully approved. Apply Director of Nursing, The Grace Hospital, 4160 John R. St., Detroit 1, Michigan.

General Duty Nurses for 680-bed General Hospital with School of Nursing. Beginning salary: $258; increase to $273 at end of 6 mos. employment. $15 increase 1 yr. after 1st increase. Differential of $10 for special services & p.m. & night duty. 40-hr. wk. 11 paid holidays. 3 wks. vacation. Free laundry. Cumulative sick leave. Temporary housing available. Apply Director of Nursing Service, General Hospital, Fresno, California.

Graduate Nurses—Attention! We're adding a few beds & will be needing a few nurses. Are you interested in working in a 50-bed active hospital close to Vancouver, B.C.? Salary & holidays according to R.N.A.B.C. recommendations. Apply Miss M. R. Ward, Langley Memorial Hospital, Langley Prairie, B.C.

Graduate Floor Duty Nurses for General Hospital, Hamilton, Ont. Gross initial bi-weekly salary: $83 plus Cost of Living Bonus of approx. $6.00 per wk. 44-hr. wk. For other perquisites & further information apply C. E. Brewster, Supt. of Nurses.

Graduate Floor Duty Nurses for Mount Hamilton Maternity Hospital, Hamilton, Ont. 44-hr. wk. Statutory holidays. Initial gross salary bi-weekly: $83 plus cost of Living Bonus. For other perquisites & further information apply Supt.

General Duty Nurses. Salary: $173.23 (one hundred seventy-three dollars & twenty-three cents) monthly, paid on a bi-weekly basis: 26 pays in a yr. Salaries have scheduled rate of increase. 48-hr. wk. 8-hr. broken day: 3-11, 11-7, rotation. Cumulative sick leave. Pension Plan in force. Blue Cross. 3 wks. vacation after 1 yr. service. Apply Supt. of Nurses, Muskoka Hospital, Gravenhurst Ont.

ANESTHESIA

A career specialty for the Graduate Nurse. ***Eligibility:*** Graduates of Accredited Schools of Nursing. ***Course:*** Study of the basic sciences related to Anesthesia. Clinical training in all phases of General Anesthesia, Resuscitation, and Inhalation Therapy. ***Professional Opportunities:*** Full-time position in teaching and non-teaching hospitals in United States. For special course write: **Mary H. Snively, R.N., In Charge of Nurses' Training Programs, Duke Hospital, Durham, North Carolina.**

Instructor of Nursing, Clinical-Obstetrical Supervisor & Operating Room Supervisor—all applicants must be qualified—for Victoria Public Hospital, Fredericton, N.B. Apply Director of Nursing.

Public Health Nurses (bilingual) for generalized program in County Health Unit. Halfway between Ottawa & Montreal. Car provided or mileage allowance on privately owned car. Minimum salary: $2,400. Apply Medical Officer of Health, Prescott & Russell Health Unit, Hawkesbury, Ont.

Dietitian (qualified) for Teaching Hospital. Opportunity for advancement. Full maintenance. Fare from Canada for accepted candidate. For full particulars write, giving qualifications & date available, Matron, King Edward VII Memorial Hospital, Bermuda.

Vancouver General Hospital invites immediate inquiries from **Graduate Nurses** for Staff Vacancies. Salaries: $222 as minimum & $258 as maximum per mo. plus shift differentials for evening & night duty. Employee benefits include: 44-hr. wk; 11 public holidays; 4 wks. vacation; 1½ days per mo. cumulative sick leave; pension plan if under 35. Acceptable qualifications for registration in B.C. necessary. Apply Director of Nursing, General Hospital, Vancouver 9, B.C.

Operating Room Supervisor. Mature person with wide experience in O.R. service. Postgraduate study desirable. Salary open. Annual increments, vacation, sick time. 48-hr. wk. Will pay travel expenses for personal interview. Also **Evening Nursery Supervisor** with experience in obstetrics. Post-graduate study desirable. Salary depends on qualifications & past experience. Additional increment for evening duty. Expenses for personal interview. Hrs., etc., as above. **General Duty Nurses.** Salary: $162.50 per mo. for new graduates. 2 meals, laundry, 8-hr. day, straight shift. $15 differential evenings; $10 nights. Vacation, sick time, statutory holidays, annual increments. Financial recognition for university, postgraduate work or yrs. of experience. Apply Supt. of Nurses, General Hospital, Winnipeg, Man.

Registered Nurses (2) for 74-bed General Hospital. 44-hr. wk., rotated shifts. 1 mo. vacation. Gross salary: $177.50 plus laundering of uniforms. $5.00 increases after 3 mos., 9 mos. & 21 mos. later. Residence accommodation available at $15 per mo. Meals available at hospital—30c. per meal. Apply Supt. of Nurses, General Hospital, Portage la Prairie, Man.

Operating Room Supervisor (special preparation preferred). Also **Dietitian & Night Supervisor** for 100-bed hospital. Salary depends on qualifications & experience. Apply Soldiers' Memorial Hospital, Campbellton, N.B.

Registered Nurse for General Duty for new 30-bed hospital. Salary: $155 per mo. plus full maintenance. Located 20 miles south of Lethbridge. For further information apply Matron, Municipal Hospital, Magrath, Alta.

Registered Nurses (2) for General Duty for Killarney & District General Hospital. Gross salary: $190 per mo. 30-bed hospital all on one floor. Excellent living quarters. Summer resort town on Lake Killarney. Apply Matron, Miss E. Nixon or F. H. White, Sec., Killarney, Man.

Registered Nurses for 34-bed General Hospital. Salary $165 per mo. for 1st yr., $175 for following yrs.; $30 per mo. extra for night duty. Full maintenance, 3 wks. vacation with pay for 1st yr., 4 wks. after 2 yrs. service. 12 days sick leave a yr., cumulative to 30 days. All statutory holidays. Travel expenses paid within Province of Manitoba for personal interview. Apply Supt. of Nurses, Altona Hospital, Altona, Man.

Graduate Nurses for 175-bed Tuberculosis Sanatorium near Prince Rupert. Salary for General Duty, $232 per mo. plus yearly increases. Room, board, laundry at $30 per mo.

Infirmières demandées par

LA SOCIÉTÉ CANADIENNE DE LA CROIX-ROUGE

- Service général dans les avant-postes hospitaliers.
- Postes d'infirmières surveillantes et infirmières visiteuses dans les avant-postes infirmiers.
- Service de Transfusion.

Les infirmières, possédant un diplôme reconnu par l'Association des Infirmières du Canada, devront faire parvenir leur demande d'emploi à l'adresse suivante:

Directrice Nationale, Service du Nursing,
La Société Canadienne de la Croix-Rouge,
95 rue Wellesley, Toronto 5, Ontario, Canada.

Transportation refunded on promise of 1 yr. service. Apply airmail, giving full details of experience, Matron, Miller Bay Indian Hospital, Box 1248, Prince Rupert, B.C.

Operating Room Nurse (qualified). Salary according to qualifications. Also **General Duty Nurses.** Gross salary $175 for active 61-bed hospital in progressive Western Ontario town with population around 4,000—about 25 miles from London. Apply Supt., General Hospital, Strathroy, Ont.

Supt. for 50-bed hospital. Must be well qualified person. Salary open. Apply, stating qualifications, experience & reference, Administrator, Wrinch Memorial Hospital, Hazelton, B.C.

General Duty Nurses for modern 50-bed hospital. Gross salary: $215 less $40 board & lodging. $10 annual increase. 10 statutory holidays. 4 wks. annual vacation. 1½ days sick leave per mo. cumulating to 36 days. Transportation allowance not exceeding $60 refunded after 1st. yr. Apply Administrator, Wrinch Memorial Hospital, Hazelton, B.C.

Graduate Nurse as Ward Supervisor — day duty. Also **General Floor Day Duty Nurses.** 44-hr. wk. Full maintenance. Apply Director of Nursing, Freeport Sanatorium, Kitchener, Ont.

University of Alberta Hospital invites applications for **General Staff Duty.** Salary: Minimum $202 & maximum $230 per mo. 44-hr. wk. 3 wks. vacation annually. 11 statutory holidays. Cumulative sick leave. Pension plan & group insurance. Blue Cross. Consideration given to request for service in following depts: General medicine, medical specialties, general surgery, surgical specialties, pediatrics, obstetrics, operating room. Cost of railway ticket to Edmonton refunded after 1 yr. continuous service. Apply Supt. of Nursing Service, University of Alberta Hospital, Edmonton, Alta.

General Staff Nurses for 300-bed hospital—medical, surgical & pediatric services. Salaries: $1,620-1,920. Additional $10 per mo. for evening or night duty. Full maintenance provided. Attractive new nurses' residence. For further information apply Director of Nursing, Tuberculosis Hospital, East Saint John, N.B.

Graduate Nurse for 6-bed hospital. Salary: $165 per mo. plus full maintenance. Only maternity & minor surgery. Apply Matron, Union Hospital, Arborfield, Sask.

Nurses for all shifts in **Psychiatric Hospital.** Temperate climate year round. Citizenship not necessary to register in state. Pleasant surroundings. 40-hr. wk. Days off together. Overtime paid for any extra hours worked. Annual leave, sick leave & paid holidays. Social Security & pension plan. **Supervisors.** 8 needed. Starting salary: $3,092. 3 yrs. experience, one of which must have been in psychiatric field. **Head Nurses.** 10 needed. Starting salary: $2,732 1 yr. of experience. If desired, complete maintenance at nominal charge. Some private baths. State registration necessary. Apply Isabel M. Reardon, R.N., Supt. of Nurses, Western State Hospital, Staunton, Virginia.

General Duty Nurses (3). Commencing salary: $220; full maintenance $45 per mo. 44-hr. wk. 28 days annual leave plus 10 statutory holidays. Annual increases & sick leave. Fare advanced if desired. Apply Director of Nursing, General Hospital, Princeton, B.C.

Clinical Instructor. Salary determined by qualifications. Apply Director of Nurses, St. Joseph Hospital, Mt. Clemens, Michigan.

NURSES WANTED

The **Indian Health Services** of the **Department of National Health & Welfare** require ***Registered Nurses & Licensed Practical Nurses*** for Hospital, fully modern Outpost Nursing Stations & Public Health Nursing positions.

Beginning Salaries — ***Registered Nurses,*** $2,300-2,720. ***Licensed Practical Nurses*** with 2 yrs. experience, $1,920-2,220. 44-hr. wk. 3 wks. leave with pay annually plus additional 12 days leave with pay in isolated areas. Educational opportunities.

Apply:

522 Dominion Public Bldg., Winnipeg, Manitoba (Telephone: 927-100).

Operating Room Supervisor with post-graduate training. **Registered Nurses for Operating Room & General Duty.** 44-hr. wk. For further information apply Director of Nursing, General Hospital, Galt, Ont.

Operating Room Supervisor. 6-room air-conditioned operating suite in new 212-bed hospital in residential section. Salary: $300 per mo.; with degree $310 per mo. Salary increases, 2½% semi-annually for 2 yrs. 1 mo. vacation. Free cotton uniform laundry. 40-hr. wk. Position available Nov. 1. Apply Director of Nursing, Sinai Hospital, 6741 W. Outer Drive, Detroit 35, Michigan.

Applications will be received by the undersigned for the position of **Supervising Nurse** for the Kent County Board of Health Unit. Applicants to have qualifications as laid down by Dept. of Public Health, Ont. Applications will also be received for a **Staff Nurse,** qualifications as laid down by Dept. of Public Health, Ont. W. M. Abraham, Sec-Treas., Kent County Board of Health, Kent County Municipal Bldg., 7th St., Chatham, Ont.

Public Health Nurse for Huron County Health Unit. Minimum salary: $2,400. Car provided or car allowance. Apply Dr. R. M. Aldis, Director, Clinton, Ont.

General Duty Nurses (3) for St. Andrews Hospital, Midland, Ont., in preparation for staffing a new hospital addition. Opportunities for other than general duty. For information re working arrangements, etc., apply Gordon A. McLean, Administrator.

Registered General Duty Nurses immediately for active 31-bed hospital. Comfortable living accommodation. Gross salary: $200 less $35 for full maintenance. 3 wks. vacation after 1 yr. service. Apply Supt., Little Long Lac Hospital, Geraldton, Ont.

Lady Supt. for 79-bed General Hospital. Apply, stating experience, age, references, to Sec., General Hospital, Kenora, Ont.

Obstetrical Supervisor with p.g. 15-bed unit plus nursery. Salary: $190 per mo. plus meals & laundry. Apply Director of Nursing, Plummer Memorial Public Hospital, Sault Ste. Marie, Ont.

Asst. Night Supervisor. Salary: $185 per mo. plus meals & laundry. Apply Director of Nursing, Plummer Memorial Public Hospital, Sault Ste. Marie, Ont.

Registered Nurses for General Duty for 50-bed hospital in town on Lake Ontario, near Toronto. Salary: $180 per mo. with additional $10 for 4-12 duty. Apply Supt. of Nurses, General Hospital, Cobourg, Ont.

Clinical Instructor (qualified) **& General Duty Staff Nurses.** Apply Director of Nurses, Royal Inland Hospital, Kamloops, B.C.

Pediatric Supervisor (properly qualified) for teaching in Accredited School of Nursing. Salary: $300 per mo. with 1 meal plus holidays. Sick leave & vacation with pay. 40-hr. wk. Apply Director of Nursing, St. Mary's Hospital, Quincy, Illinois.

Asst. Supervisor for Children's Dept. in large General Hospital in vicinity of Toronto. Apply, giving qualifications & experience, c/o Box B, The Canadian Nurse, Ste. 522, 1538 Sherbrooke St. W., Montreal 25, Que.

Asst. Dietitian (qualified) for 225-bed hospital. Apply Chief Dietitian, Moncton Hospital, Moncton, N.B..

THE BRITISH COLUMBIA CIVIL SERVICE
requires—Instructors (2) for the
School of Psychiatric Nursing, Essondale, B.C.

Salary: $239 rising to $266 per month.
Qualifications: Eligible for registration in British Columbia and have certificate in teaching and supervision and post-graduate study (or its equivalent) and experience in psychiatric nursing. Candidates must be British subjects and under 40 years of age except in the case of ex-service women who are given preference.

Further information and application forms may be obtained from:
Director of Nursing, Provincial Mental Hospital, Essondale, B.C.
or **B.C. Civil Service Commission, Weiler Bldg., Victoria, B.C.**

Night Supervisor (1) & 3-11 Supervisor (1) for well equipped 70-bed hospital with all graduate staff. Must be capable of taking charge in delivery & operating rooms. Salary: $170 per mo. plus full maintenance. Annual increases. Apply Supt. of Nurses, Douglas Memorial Hospital, Fort Erie, Ont.

Registered Nurses (white) for 100-bed General Hospital. 3 shifts. Excellent salary. 6 paid holidays. 12 paid sick days per yr. 2-wk. paid vacation after 1 yr. service. Apply Director of Nursing, Zieger Osteopathic Hospital, 4244 Livernois, Detroit 10, Michigan. (Phone TA 6-6400).

Graduate Nurses for Floor Duty in modern 50-bed General Hospital. Also **Operating Room Scrub Nurse.** Apply Supt., District Memorial Hospital, Leamington, Ont.

Nurses (2) for 24-bed hospital & nurses' home both up to date & modern. Salary: $175 per mo. with full maintenance. Usual holidays with pay, sick leave, etc. Transportation refunded if nurse stays a yr. or longer. Apply Matron, Union Hospital, Vanguard, Sask.

Director of Public Health Nursing for Dept. of Health, City of Ottawa. Staff of 22 nurses & 4 supervisors. Generalized public health nursing program. Apply Dr. J. J. Day, Medical Officer of Health, Transportation Bldg., 48 Rideau St., Ottawa 2, Ont.

Immunization Week

The observance of specially named weeks or days is so commonplace today that our attention tends to become dulled. Nevertheless, so important a reminder of the prevention of communicable disease as National Immunization Week continues to merit our interest and support.

This year the Health League of Canada observed the tenth of its annual celebrations during the week of October 12-18. The primary purpose of thus concentrating special attention on the value of immunization is to refresh the memories of both the lay and professional public with the importance of preventing the occurrence of smallpox, whooping cough, tetanus, and diphtheria, in particular.

Popular opinion to the contrary, whooping cough is one of the deadliest of childhood diseases. Among children under two years of age, whooping cough takes a higher toll of life than polio, diphtheria, measles, and scarlet fever combined. Of the various communicable diseases encountered today, whooping cough presents the chief problem from the standpoint of securing parental cooperation for immunization. The urgency of administering the vaccine early—by six months of age or even earlier—cannot be stressed too strongly if the high mortality rate is to be cut.

To make protection easier for both parents and children, a combination of whooping cough vaccine and diphtheria and lockjaw toxoid can now be given, either by the family doctor or at public health clinics.